Connecticut Department of Public Health
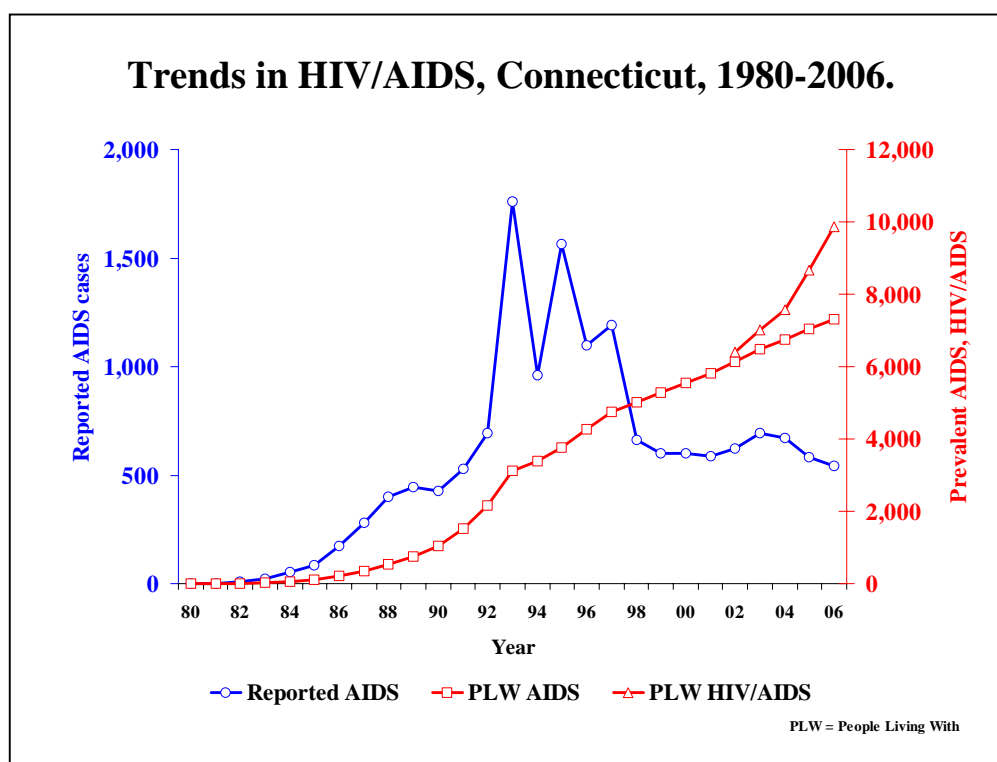## *AIDS and Chronic Diseases Section*

Epidemiologic Profile of HIV/AIDS in Connecticut

– 2007 –

Trends in HIV/AIDS, Connecticut, 1980-2006.

Reported AIDS cases

Prevalent AIDS, HIV/AIDS

Year

—○— Reported AIDS   —□— PLW AIDS   —△— PLW HIV/AIDS

PLW = People Living With

CONNECTICUT DEPARTMENT OF
PUBLIC HEALTH

Connecticut Department of Public Health

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Executive Summary

The Connecticut Department of Public Health periodically produces an Epidemiologic Profile of HIV/AIDS in Connecticut. The purpose of the profile is to provide epidemiologic data to the Community Planning Group, the Ryan White Consortia, and others for planning purposes. The previous profile was produced in 2003 and supplemented in 2004. There are a number of important features in the 2007 profile: 1) standard surveillance information about HIV and AIDS trends; 2) enhanced information about HIV (not AIDS) made possible by implementation of HIV reporting in 2002; 3) tables with persons living with AIDS have been modified to include both HIV and AIDS; 4) information about HIV testing in both the general population and people recently diagnosed with HIV infection; 5) information about behavioral characteristics that place people at risk for HIV infection are included from the Behavioral Risk Factor Surveillance System, the School Health Survey, and the National HIV Surveillance System, all conducted by DPH in 2005; 6) hepatitis C surveillance data plus information about HCV/HIV co-infected people; and, 7) data are also included from the HIV counseling and testing system, sexually transmitted diseases surveillance system, and the US Census.

A quick look at HIV/AIDS in Connecticut:

- From 1981 to 2006, 14,917 cases of AIDS were reported to the Connecticut Department of Public Health (DPH). Since 2002, an additional 2,561 cases of HIV (not AIDS) were reported for a total of 17,478 HIV/AIDS cases. AIDS cases have been reportable to DPH since 1981. HIV (not AIDS) was made reportable in 2002.

- Since 2002, an average of 1,138 HIV/AIDS cases were reported per year.

- New AIDS cases were diagnosed at a rate of 15.1 per 100,000 population per year in 2003-04. AIDS cases continue to be diagnosed at higher rates in blacks and Hispanics (53.0 and 58.1 per 100,000, respectively) compared with whites (6.3 per 100,000).

- At the end of 2006, 9,871 people had been reported living with HIV/AIDS (PLWHA) (281.2 per 100,000). Of PLWHA, 65.8% are male, 34.2% are female, 35.0% are white, 31.3% are black, and 32.4% Hispanic. Nearly half (43.0%) of cases are associated with injection drug use (IDU) with 19.5% associated with men who have sex with men (MSM), and 22.2% with heterosexual risk. Only 5.8% of PLWHA are less than 30 years of age, 18.0% are 30-39, 42.7% are 40-49, and 33.6% are 50 or older.

- 47.0% of PLWHA live in the cities of Hartford, New Haven, or Bridgeport.

- Since 1981, there have been 7,668 deaths in persons with HIV/AIDS (43.9% of reported HIV/AIDS cases). Deaths decreased dramatically during the late 1990s due to advances in treatment. However, HIV/AIDS is still an important cause of death, especially in blacks and Hispanics. During 1998-2003 deaths averaged 291 per year.

- In 2005, 37.4% of Connecticut residents aged 18-64 reported having ever been tested for HIV (34.0% of whites, 63.3% of blacks, and 50.4% of Hispanics).

- In 2006, of 64 cases of syphilis reported statewide, 85.9% were in MSM.

Introduction

- *What is an Epidemiologic Profile?*

  o The Epidemiologic Profile is a document prepared by the Department of Public Health describing HIV/AIDS in Connecticut. As provided in the Centers for Disease Control and Prevention (CDC) guidance, the goals of the Epidemiologic Profile are the following:

    ▪ Provide a thorough description of the HIV/AIDS epidemic among the various populations (overall and subpopulations) in Connecticut;

    ▪ Describe the current status of HIV/AIDS cases in Connecticut and provide some understanding of how the epidemic may look in the future;

    ▪ Identify characteristics of the general population and of populations who are living with, or at high risk for, HIV/AIDS in defined geographical areas and who need primary and secondary prevention or care services;

    ▪ Provide information required to conduct needs assessments and gap analyses.

- *Organization of the Epidemiologic Profile:*

  o *CDC Guidance:* The CDC provides guidance for the production of Epidemiologic Profiles. In the most recent version of CDC guidance, it is recommended that state Epidemiologic Profiles provide information for both:

    ▪ Prevention: Community Planning Group;

    ▪ Care: Ryan White.

  o *Population:* This information is included to provide background about the makeup of Connecticut's population in terms of race, ethnicity, education, and economics. Additional information can be found at www.census.gov.

  o *HIV/AIDS Surveillance:* The majority of the material presented is from the HIV/AIDS surveillance system. The data in this section are current through the end of 2006. This material is organized into several sections that include information about cumulative AIDS cases, trends in AIDS cases by year of report, incidence of AIDS, AIDS deaths, people living with HIV/AIDS, HIV (not AIDS), and HIV in children. Other sections describe HIV/AIDS cases in CPG regions and Ryan White Transitional Grant Areas (TGA).

  o *Connecticut Counseling and Testing:* Publicly funded HIV counseling collect a variety of de-identified client information. DPH compiles the data and provides updates on the DPH website. Data for 2006 is included in this report.

- o ***Behavioral Risk Factor Survey:*** This survey is a random, weighted telephone survey conducted annually in Connecticut. Several questions about HIV are included in the survey and offer insight into HIV testing and risk behavior in the general population. Selected results from the 2005 survey are included in this report.

- o ***School Health Survey:*** This survey is conducted in consenting schools with high school students, grades 9-12. Questions are included about sexual and drug use activity, and whether or not students have received HIV prevention education. Selected results from the 2005 survey are included in this report.

- o ***Sexually Transmitted Diseases Surveillance:*** This information is relevant to HIV prevention because STDs can be transmitted in the same manner as HIV, and tend to get diagnosed and reported much sooner after infection than HIV. The high proportion of recent syphilis cases associated with MSM highlights this connection with HIV. Data through the end of 2006 are included in this report.

- o ***Hepatitis C Surveillance:*** This data is of interest to HIV prevention and care because, in Connecticut, IDU is the predominant risk group for both hepatitis C and HIV. Information is also provided about co-infection with HIV and hepatitis C.

- • ***Reading the Epidemiologic Profile:***

  - o The contents are presented in seven sections.

  - o Each of the sections can be read as a stand-alone document.

  - o Within each section, subsections are numbered, based on the number of the section in which they appear. For example, Section 2, about various HIV/AIDS surveillance topics, has nine subsections, 2.1 to 2.9.

  - o Tables and figures are numbered according to their section. For example, two tables in subsection 2.1 would be numbered 2.1.1 and 2.1.2. Figures and Tables are numbered in individual sequence. For example, there could be both a Table 1.1.1 and a Figure 1.1.1.

  - o Many of the HIV/AIDS tables included here can also be found on the HIV/AIDS Surveillance website (www.dph.state.ct.us).

- • ***Other sources of information about HIV and AIDS:***

  - o HIV/AIDS Surveillance Program website (www.dph.state.ct.us). The web page information will be updated in January and July each year.

  - o *2003 HIV/AIDS Epidemiologic Profile* (www.dph.state.ct.us)

  - o 20th Anniversary of AIDS in Connecticut – *Connecticut Epidemiologist* http://www.dph.state.ct.us/BCH/infectiousdise/pdf/ce_12_2001.pdf (2001)

  - o HIV/AIDS statistics for other states (http://www.statehealthfacts.org)

- o CDC website (www.cdc.gov)

  - National HIV/AIDS statistics
    (http://www.cdc.gov/hiv/topics/surveillance/index.htm)

  - Cases of HIV infection and AIDS in the United States (2005)
    (http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/pdf/2005SurveillanceReport.pdf)

  - Selected MMWR articles (2006-07)

    - National Black HIV/AIDS Awareness Day --- February 7, 2007
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5604a1.htm

    - HIV/AIDS Diagnoses Among Blacks --- Florida, 1999—2004
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5604a2.htm

    - Racial/Ethnic Disparities in Diagnoses of HIV/AIDS --- 33 States, 01-04.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5505a1.htm

    - Evolution of HIV/AIDS Prevention Programs --- United States, 81-06.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a4.htm

    - Epidemiology of HIV/AIDS --- United States, 1981—2005.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a2.htm

    - Twenty-Five Years of HIV/AIDS --- United States, 1981—2006.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a1.htm

    - Human Immunodeficiency Virus (HIV) Risk, Prevention, and Testing
      Behaviors --- United States, National HIV Behavioral Surveillance System:
      Men Who Have Sex with Men, November 2003--April 2005.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5506a1.htm

    - Revised Recommendations for HIV Testing of Adults, Adolescents, and
      Pregnant Women in Health-Care Settings.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

    - Missed Opportunities for Earlier Diagnosis of HIV Infection --- South
      Carolina, 1997—2005.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5547a2.htm

Section 1:   Connecticut's People

- Information in this section comes primarily from the 2000 Census. However, 2005 population estimates are available for some demographic characteristics (Table 1.1). Where possible, 2005 estimates are used in the calculation of rates. During 2000 to 2005 it is estimated that the population of Connecticut increased by 3.1% with small increases in the percentages of Hispanic and black residents.

- The US Census includes information about demographics, socio-economic status, and much more. Selected information for Connecticut is shown in Table 1.2 by county and Table 1.3 by cities with populations of more than 20,000. Additional information about US and Connecticut Census data can be found at www.census.gov.

Table 1.1: Population Changes in Connecticut, 2000-2005.

		Connecticut	USA
	2000	2005 (est)	2005 (est)
Population	3,405,565	3,510,297	296,410,404
% change, 2000-2005	--	3.1%	5.3%
White	81.6%	84.9%	80.2%
Black	9.1%	10.1%	12.8%
Hispanic[1]	9.4%	10.9%	14.4%

[1]Hispanic can be of any race.

- In the 2000 Census the population of Connecticut was 3,405,565.

  - 81.6% white, 9.1% black, 0.3% American Indian, <0.1% Native Hawaiian, 2.2% two or more races, and 9.4% Hispanic (of any race);

  - The majority of Hispanics are Puerto Rican (194,443; 60.7%), followed by Mexican (23,484; 7.3%), Cuban (7,101; 2.2%), and Others (95,292; 29.7%);

  - Foreign born: 10.9%;

  - Other than English at home: 18.3%;

  - High school or more education: 84.0%;

  - Live below the poverty line: 7.9%;

  - Per capita income: $28,766;

  - There are 3,559 households with an unmarried male with a male partner.

- Three counties, Fairfield, Hartford, and New Haven, include 75.3% of all Connecticut residents (Table 1.2). They also include the highest percentage of black (10.0-11.7%) and Hispanic (10.1-11.9%) residents, the highest percentage that speak other than English at home (17.7-23.9%), and the highest percentage of foreign born (9.0-16.9%).

- Fairfield County has the highest per capita income ($38,350) and Windham County has the lowest ($20,443).

Census Data for Cities and Towns (>20,000 Population)

- Five cities have populations greater than 100,000: Bridgeport (139,529), New Haven (123,626), Hartford (121,578), Stamford (117,083), and Waterbury (107,271) (Table 1.3).

- The three largest cities have majority populations of black and Hispanic: Bridgeport (31% black, 32% Hispanic), New Haven (37% black, 21% Hispanic), and Hartford (38% black, 41% Hispanic).

- Cities under 50,000 tend to have very small black and Hispanic populations with several notable exceptions:

    o Windsor (pop 28,237) is 65% white, 27% black, and only 5% Hispanic;

    o Windham (pop 22,857) is 74% white, 27% Hispanic, and only 5% black;

    o New London (pop 25,671) is 63% white, 19% black, and 20% Hispanic.

- There are few American Indian and Alaskan Natives (1.2% in Norwich and 0.8% in Groton).

- Asians are generally 1-4% of the population with some exceptions: Stamford (5.0%), Danbury (5.5%), Greenwich (5.2%), and Mansfield (7.2%).

- Native Hawaiians and other Pacific Islanders range from 0.0% in many cities to a high of 0.2% in Groton.

- "Other" race ranges from 0.3% to 26.5%. Notably, cities with a high percentage of "other" tend to have a higher percentage of Hispanics.

- Of respondents in cities with greater than 20,000, 7-40% speak other than English at home with most cities above 10%.

- The percentage with a high-school education or more ranges from 61%-96%, in Hartford and Westport, respectively.

- The percentage below the poverty line ranges from 2-31% and per capita income ranges from $13,428 (Hartford) to $74,346 (Greenwich). Most cities are $20,000 to $40,000 with five cities above $40,000: Glastonbury ($40,820), Fairfield ($43,670), Ridgefield ($51,795), Westport ($73,664), and Greenwich ($74,346). Four of the five are in Fairfield County.

Table 1.2: 2000 CENSUS DATA: Connecticut Counties by Race/Ethnicity[1,2,3,4], and Socio-economic Characteristics.

	Population	White	Black or AA[3]	AI& AN[3]	Asian	NH& OPI[3]	Other	Two or more races[2]	Hisp or Latino[4]	Foreign born	Other than English at home	High school or more	Persons below poverty line	Per capita income
Connecticut	3,405,565	81.6	9.1	0.3	2.4	<0.1	4.3	2.2	9.4	10.9	18.3	84.0	7.9	$28,766
FAIRFIELD	882,567	79.3	10.0	0.2	3.3	<0.1	4.7	2.5	11.9	16.9	23.9	84.4	6.9	$38,350
HARTFORD	857,183	76.9	11.7	0.2	2.4	<0.1	6.4	2.3	11.5	11.7	21.7	82.4	9.3	$26,047
NEW HAVEN	824,008	79.4	11.3	0.2	2.3	<0.1	4.5	2.2	10.1	9.0	17.7	83.0	9.5	$24,439
NEW LONDON	259,088	87.0	5.3	1.0	2.0	0.1	2.1	2.7	5.1	5.4	10.3	86.0	6.4	$24,678
LITCHFIELD	182,193	95.8	1.1	0.2	1.2	<0.1	0.7	1.1	2.1	5.4	8.2	85.9	4.5	$28,408
MIDDLESEX	155,071	98.4	4.4	0.2	1.6	<0.1	1.0	1.6	3.0	4.5	9.5	88.7	4.6	$28,251
TOLLAND	136,364	92.3	2.7	0.2	2.3	<0.1	1.1	1.4	2.8	5.9	10.0	89.2	5.6	$25,474
WINDHAM	109,091	91.3	1.9	0.5	0.8	<0.1	3.6	1.9	7.1	4.3	11.7	79.6	8.5	$20,443

Note: Percent

[1]Census respondents had the option of selecting more than one race.

[2]Data shown includes persons reporting only one race. "Two or more" includes persons who selected more than one race.

[3]AA = African American; AI&AN = American Indian and Alaskan Native; NH&OPI = Native Hawaiian and other Pacific Islander.

[4]Race groups should add to 100% (including 'two or more'). "Hispanic or Latino" is a separate category. Race data include Hispanic and non-Hispanic. For example, 81.6% of Connecticut's population is white (Hispanic and non-Hispanic), as shown in the table, but 77.5% are white, non-Hispanic.

Table 1.3: 2000 CENSUS DATA: Connecticut Cities and Towns (>20,000 Population) by Race/Ethnicity[1,2,3,4], and Socio-economic Characteristics.

| | | | | | | | Percent | | | | | | |
	Population	White	Black or AA	AI &AN	Asian	NH &OPI	Other	Two or more races	Hisp or Latino	Other than English at home	High school or more	Below poverty line	Per capita income
Bridgeport	139,529	45	31	0.5	3.3	0.1	14.8	5.6	32	44	65	18	$16,306
New Haven	123,626	43	37	0.4	3.9	0.1	10.9	3.9	21	28	74	24	$16,393
Hartford	121,578	28	38	0.5	1.6	0.1	26.5	5.4	41	47	61	31	$13,428
Stamford	117,083	70	15	0.2	5.0	0.0	6.5	3.1	17	35	82	8	$34,987
Waterbury	107,271	67	16	0.4	1.5	0.1	10.9	3.7	22	30	72	16	$17,701
Norwalk	82,951	74	15	0.2	3.3	0.0	4.3	2.9	16	27	83	7	$31,781
Danbury	74,848	76	7	0.3	5.5	0.0	7.6	4.0	16	35	77	8	$24,500
New Britain	71,538	69	11	0.4	2.4	0.1	13.1	3.8	27	43	69	16	$18,404
West Hartford	63,589	86	5	0.1	4.8	0.1	2.6	1.7	6	22	90	5	$33,468
Greenwich	61,101	90	2	0.1	5.2	0.0	1.5	1.6	6	21	92	4	$74,346
Bristol	60,062	92	3	0.2	1.5	0.0	2.4	1.6	5	16	81	7	$23,362
Meriden	58,244	80	6	0.4	1.4	0.0	8.6	2.9	21	24	78	11	$20,597
Fairfield	57,340	95	1	0.1	2.0	0.0	0.5	1.0	2	12	92	3	$43,670
Hamden	56,913	77	16	0.1	3.5	0.0	1.6	1.9	4	14	89	8	$26,039
Manchester	54,740	83	8	0.2	3.2	0.0	3.1	2.3	7	14	88	8	$25,989
West Haven	52,360	74	16	0.2	2.9	0.1	3.6	2.8	9	18	81	9	$21,121
Milford	52,305	94	2	0.1	2.3	0.0	0.9	1.1	3	11	89	4	$28,882
Stratford	49,976	85	10	0.2	1.4	0.0	2.1	1.7	7	15	83	5	$26,501
East Hartford	49,575	65	19	0.3	4.0	0.0	8.7	3.4	15	26	77	10	$21,763
Enfield	45,212	90	6	0.2	1.3	0.0	1.6	1.5	4	10	84	4	$21,967
Middletown	43,167	80	12	0.2	2.7	0.0	2.0	2.8	5	15	84	8	$25,720
Wallingford	43,026	95	1	0.2	1.8	0.0	1.2	1.1	5	12	86	4	$25,947
Groton	39,907	84	7	0.8	3.3	0.2	1.7	3.5	5	9	88	6	$23,995
Southington	39,728	96	1	0.1	1.0	0.0	0.6	1.0	2	10	86	3	$26,370
Shelton	38,101	94	1	0.1	2.1	0.0	0.9	1.3	3	15	87	3	$29,893

Town	Population	White	AA	AI&AN	Asian	NH&OPI		Two or more					Median income
Norwich	36,117	83	7	1.2	2.1	0.0	2.8	3.9	6	14	79	12	$20,742
Torrington	35,202	93	2	0.2	1.8	0.0	1.3	1.5	3	11	78	7	$21,406
Trumbull	34,243	94	2	0.1	2.4	0.0	0.7	0.9	3	14	90	2	$34,931
Glastonbury	31,876	93	2	0.1	3.4	0.0	0.9	0.9	3	11	94	2	$40,820
Naugatuck	30,989	92	3	0.3	1.7	0.0	1.6	1.8	4	18	83	6	$22,757
Newington	29,306	92	2	0.1	2.8	0.0	1.2	1.3	4	20	86	4	$26,881
Branford	28,683	94	1	0.1	2.7	0.1	0.5	1.2	3	9	91	4	$32,301
Cheshire	28,543	89	5	0.2	2.6	0.0	1.9	1.2	4	10	92	3	$33,903
Windsor	28,237	65	27	0.2	3.1	0.0	2.1	2.4	5	13	88	4	$27,633
East Haven	28,189	94	1	0.1	1.9	0.0	1.5	1.1	4	12	82	5	$22,396
Vernon	28,063	90	4	0.2	2.7	0.0	1.2	1.9	4	11	86	6	$25,150
New Milford	27,121	94	1	0.1	1.9	0.0	0.7	1.5	3	8	91	3	$29,630
Wethersfield	26,271	93	2	0.1	1.6	0.0	1.8	1.2	4	21	84	4	$28,930
Westport	25,749	95	1	0.0	2.4	0.0	0.4	0.8	2	12	96	3	$73,664
New London	25,671	63	19	0.9	2.1	0.1	9.1	5.7	20	24	78	16	$18,437
Newtown	25,031	95	2	0.1	1.4	0.0	0.6	0.9	2	8	93	3	$37,786
South Windsor	24,412	91	3	0.2	3.7	0.0	0.7	1.0	2	14	91	2	$30,966
Ridgefield	23,643	96	1	0.1	2.1	0.0	0.4	0.7	2	9	96	2	$51,795
Farmington	23,641	93	2	0.1	3.7	0.0	0.6	1.1	2	17	92	5	$39,102
Simsbury	23,234	95	1	0.1	2.1	0.0	0.3	1.0	2	8	95	2	$39,710
North Haven	23,035	93	2	0.1	3.4	0.0	0.5	0.8	2	11	87	4	$29,919
Windham	22,857	74	5	0.6	1.3	0.1	15.2	3.8	27	28	74	18	$16,978
Watertown	21,661	96	1	0.1	1.3	0.0	0.5	0.9	2	13	84	2	$26,044
Guilford	21,398	96	1	0.0	1.6	0.0	0.4	0.9	2	7	95	3	$37,161
Mansfield	20,720	84	5	0.2	7.2	0.0	1.9	1.9	4	18	91	14	$18,094

[1]Census respondents had the option of selecting more than one race.

[2]Data shown includes persons reporting only one race. "Two or more" includes persons who selected more than one race.

[3]AA = African American; AI&AN = American Indian and Alaskan Native; NH&OPI = Native Hawaiian and other Pacific Islander.

[4]Race groups should add to ~100% (including 'two or more'). "Hispanic or Latino" is a separate category. Race data include Hispanic and non-Hispanic. For example, 81.6% of Connecticut's population is white (Hispanic and non-Hispanic), as shown in the table, but 77.5% are white, non-Hispanic.

Section 2: HIV/AIDS Surveillance

- In this section, Connecticut HIV/AIDS surveillance data are provided in nine subsections: 2.1 Cumulative AIDS Cases; 2.2 Trends in HIV/AIDS Cases; 2.3 Incidence of HIV/AIDS; 2.4 HIV/AIDS Deaths and Hospitalizations; 2.5 People Living with HIV/AIDS; 2.6 HIV Surveillance; 2.7 HIV/AIDS in Children and Adolescents; 2.8 Reason for Testing in Newly Diagnosed HIV Cases; and, 2.9 HIV Testing at Publicly Funded Counseling and Testing Sites.

- AIDS was made reportable in 1981. In 2002, HIV in adults was made reportable. In 2006, laboratory results for HIV viral load tests were made reportable.

2.1 Cumulative AIDS Cases

- Since 1981, 14,917 cases of AIDS have been reported (through December 2006). Of these, 7,607 (51.0%) have died and 7,310 are living with AIDS (Table 2.1.1).

- AIDS cases are disproportionately male. Overall, 71.8% of AIDS cases are male compared to 48% of the population (Figure 2.1.1). AIDS cases are also disproportionately black and Hispanic. While 8.7% of the population is black and 9.4% is Hispanic, 36.4% of AIDS cases are black and 26.1% are Hispanic (Figure 2.1.2).

- Cumulatively, 48.8% of AIDS cases are IDU, 22.1% are MSM, 3.1% are MSM/IDU, 18.2% are heterosexual and 6.5% are other or unknown. Only 1.4% (n=208) are in children (<13 years) (Table 2.1.2). Among adult males the predominant risk groups are IDU (48.7%) and MSM (31.0%) and among females, IDU (51.6%) and heterosexual (41.5%) (Figure 2.1.3).

- While the majority of white males are MSM (53.0%) and a minority are IDU (28.5%), among black and Hispanic males the proportions are approximately reversed with 15% MSM and 60% IDU. White and black females are more likely to be IDU and Hispanic females are equally associated with heterosexual transmission and IDU (Table 2.1.2).

- 3,292 AIDS cases have been reported with MSM risk: 68.9% white, 17.9% black, and 12.5% Hispanic (Table 2.1.2).

- Among non-MSM adult males with known risk (n=6,161), 83.7% are IDU and 16.3% are heterosexual. Among adult females with known risk (n=3,832), 55.4% are IDU and 44.6% are heterosexual (Table 2.1.2).

- Figures 2.1.4 – 2.1.6 show the distribution of AIDS cases by age group.
  - Sex: The majority of cases are male with the percentage of males increasing from 63% in the 13-29 age group to 79% in the 50+ age group.
  - Race: The percentage of cases that are Hispanic decreases with increased age (35% to 20%) and the percentage of white cases increases with age (33% to 45%). The percentage of black cases remains approximately constant in all the age groups (33% to 37%).
  - Risk: IDU risk is highest in all age groups (39%, 54%, 36%).

Figure 2.1.1: The Percentage of Males/Females in the General Population and AIDS Cases, Connecticut, 2006.

Population

AIDS Cases

Female 52%
Male 48%
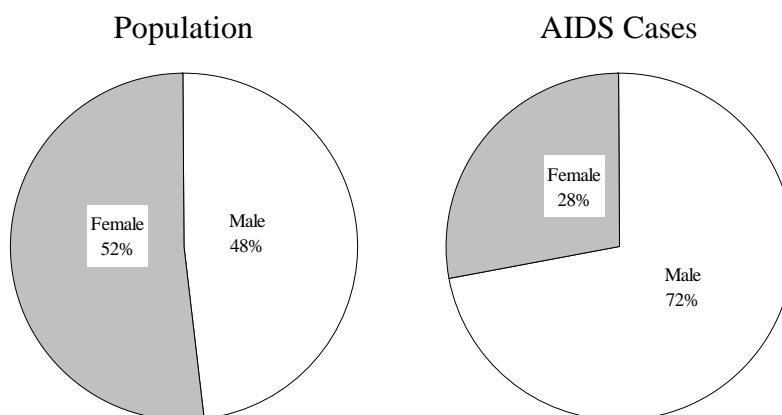
Female 28%
Male 72%

Figure 2.1.2: Race/Ethnicity in the General Population and AIDS Cases, Connecticut, 2006.

Population

AIDS Cases

Black 8.7%
Hispanic 9.4%
Other 4.4%
White 77.5%

Other 0.7%
White 36.9%
Black 36.4%
Hispanic 26.1%

Figure 2.1.3: Cumulative Distribution of Adult Male and Female AIDS Cases, by Risk Group, Connecticut, 2006.

Males

Females

Figure 2.1.4: Cumulative AIDS Cases by Sex, and Age at Diagnosis, Connecticut, 2006.

Figure 2.1.5: Cumulative AIDS Cases by Race, and Age at Diagnosis, Connecticut, 2006.

Figure 2.1.6: Cumulative AIDS Cases by Risk Group, and Age at Diagnosis, Connecticut, 2006.
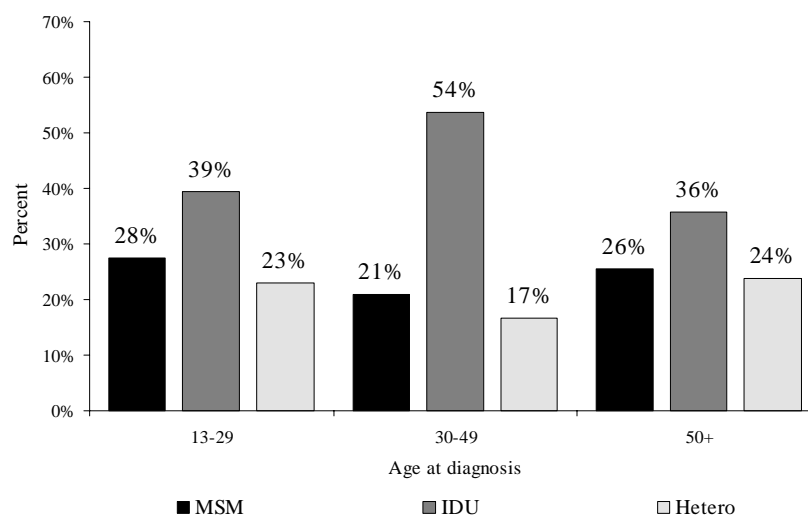
Table 2.1.1: HIV/AIDS Surveillance Data by Year of Report, Diagnosis, Death, Prevalence, Connecticut, 1980-2006.

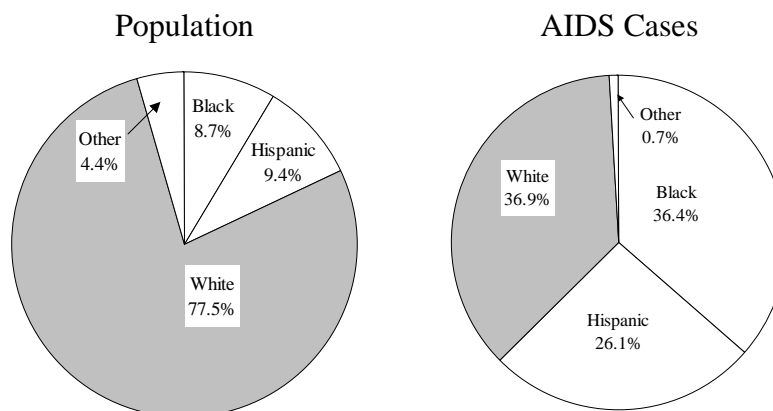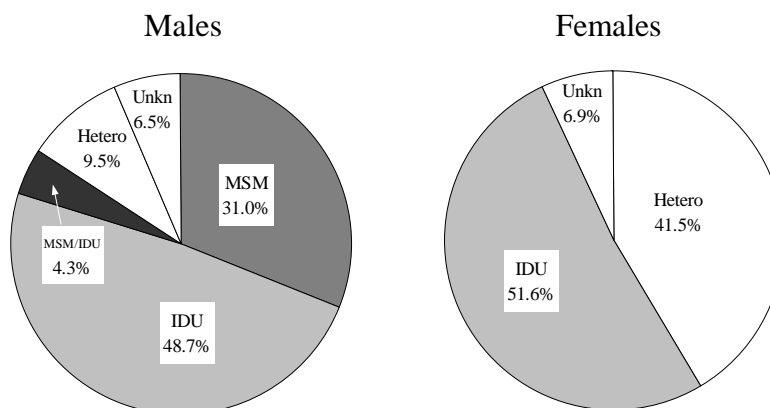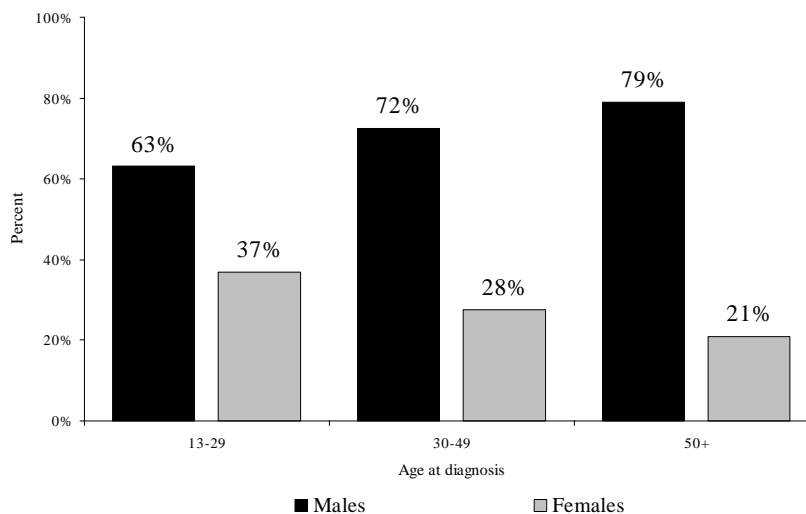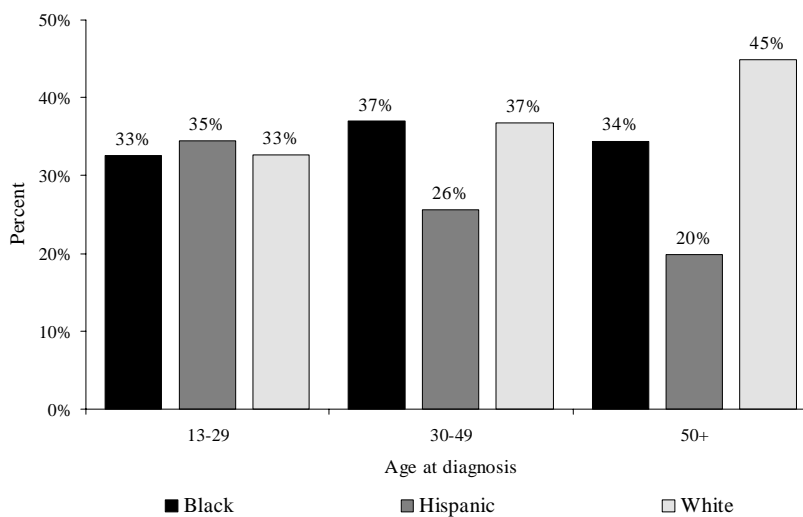| Year[1]	Reported AIDS	Diagnosed AIDS	AIDS deaths[2,3]	Prevalent AIDS[4]	Reported HIV[5]	Current HIV[6]	HIV deaths[2,3,7]	Prevalent HIV/AIDS[8]
1980-86	344	499	295	204	.	.	.	.
1987	277	334	195	343	.	.	.	.
1988	397	422	245	520	.	.	.	.
1989	447	534	315	739	.	.	.	.
1990	422	609	335	1,013	.	.	.	.
1991	527	877	415	1,475	.	.	.	.
1992	677	1,173	539	2,109	.	.	.	.
1993	1,731	1,573	657	3,025	.	.	.	.
1994	938	1,085	722	3,388	.	.	.	.
1995	1,521	1,199	830	3,757	.	.	.	.
1996	1,063	1,106	576	4,287	.	.	.	.
1997	1,160	806	328	4,765	.	.	.	.
1998	634	587	312	5,040	.	.	.	.
1999	576	579	312	5,307	.	.	.	.
2000	574	578	302	5,583	.	.	.	.
2001	551	537	279	5,841	.	.	.	.
2002	590	602	265	6,178	431	263	12	6,441
2003	692	547	249	6,476	410	266	14	7,005
2004	670	478	199	6,755	413	300	10	7,584
2005	583	446	173	7,028	955	816	15	8,673
2006	543	346	64	7,310	1,038	916	10	9,871
Total	14,917	14,917	7,607		3,247	2,561	61	

[1] Data in recent years is incomplete due to delay in the reporting of cases and/or deaths.

[2] Deaths in 2005-06 represent only partial reporting from the DPH Vital Records Section.

[3] Death data is obtained from death certificates or health-care providers. Deaths due to HIV/AIDS related illness that do not list HIV/AIDS as a cause of death or that occur out-of-state may not be included. Deaths due to non-HIV/AIDS causes (i.e. auto accident, drug overdose) may not be included.

[4] Prevalent cases are persons living with AIDS or HIV, or whose mortality status is unknown. May include persons who have moved out of state or persons who have died of non-HIV/AIDS related causes.

[5] HIV infection became a reportable disease in Connecticut on January 1, 2002.

[6] A person with HIV infection who has not developed AIDS.

[7] HIV deaths represents the number of deaths in HIV cases (not reported as AIDS cases).

[8] Prevalent HIV or AIDS represents the number of HIV and AIDS cases currently living with HIV or AIDS.

Table 2.1.2: Cumulative Reported AIDS Cases by Sex, Race/Ethnicity, and Risk Group, Connecticut, 1980-2006.

		MSM N	MSM % of row total	IDU N	IDU % of row total	MSM/IDU N	MSM/IDU % of row total	Hetero N	Hetero % of row total	Oth/unk N	Oth/unk % of row total	Pedi N	Pedi % of row total	Total N	Total % of total
Male	White	2,268	53.0	1,219	28.5	191	4.5	265	6.2	320	7.5	15	0.4	4,278	28.7
	Black	586	15.8	2,239	60.5	170	4.6	458	12.4	184	5.0	64	1.7	3,701	24.8
	Hispanic	412	15.5	1,677	63.1	98	3.7	268	10.1	168	6.3	33	1.2	2,656	17.8
	Other	26	36.1	24	33.3	1	1.4	11	15.3	10	13.9	--	--	72	0.5
Female	White	--	--	677	55.4	--	--	421	34.5	111	9.1	13	1.1	1,222	8.2
	Black	--	--	892	51.8	--	--	698	40.5	81	4.7	51	3.0	1,722	11.5
	Hispanic	--	--	541	43.8	--	--	580	46.9	84	6.8	31	2.5	1,236	8.3
	Other	--	--	13	43.3	--	--	10	33.3	6	20.0	1	3.3	30	0.2
White		2,268	41.2	1,896	34.5	191	3.5	686	12.5	431	7.8	28	0.5	5,500	36.9
Black		586	10.8	3,131	57.7	170	3.1	1,156	21.3	265	4.9	115	2.1	5,423	36.4
Hispanic		412	10.6	2,218	57.0	98	2.5	848	21.8	252	6.5	64	1.6	3,892	26.1
Other		26	25.5	37	36.3	1	1.0	21	20.6	16	15.7	1	1.0	102	0.7
Total		3,292	22.1	7,282	48.8	460	3.1	2,711	18.2	964	6.5	208	1.4	14,917	100.0

Table 2.1.3: Cumulative AIDS Cases by Sex, Race/Ethnicity, and Age Group, Connecticut, 1980-2006.

| | | Age group | | | | | | | | | | | |
| | | 0-12 | | 13-19 | | 20-29 | | 30-39 | | 40-49 | | 50+ | | Total |
		N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Male	White	12	0.3	12	0.3	435	10.2	1,749	40.9	1,350	31.6	720	16.8	4,278	28.7
	Black	57	1.5	10	0.3	350	9.5	1,507	40.7	1,287	34.8	490	13.2	3,701	24.8
	Hispanic	31	1.2	10	0.4	420	15.8	1,195	45.0	729	27.4	271	10.2	2,656	17.8
	Other	--	--	--	--	8	11.1	28	38.9	22	30.6	14	19.4	72	0.5
Female	White	11	0.9	9	0.7	186	15.2	529	43.3	358	29.3	129	10.6	1,222	8.2
	Black	47	2.7	14	0.8	272	15.8	779	45.2	450	26.1	160	9.3	1,722	11.5
	Hispanic	27	2.2	10	0.8	241	19.5	530	42.9	325	26.3	103	8.3	1,236	8.3
	Other	1	3.3	--	--	1	3.3	16	53.3	9	30.0	3	10.0	30	0.2
Male		100	0.9	32	0.3	1,213	11.3	4,479	41.8	3,388	31.6	1,495	14.0	10,707	71.8
Female		86	2.0	33	0.8	700	16.6	1,854	44.0	1,142	27.1	395	9.4	4,210	28.2
Total		186	1.2	65	0.4	1,913	12.8	6,333	42.5	4,530	30.4	1,890	12.7	14,917	100.0

2.2 Trends in HIV/AIDS Cases

Trends in AIDS cases

- The first reported Connecticut AIDS case was in 1981. The highest number of AIDS cases was reported in 1993 (n=1,731). Since 1998, the annual number of AIDS cases has fluctuated between 543 and 692 with an average of 601 per year (Table 2.2.1).

- Trends in reported AIDS cases have been very gradual. (Figure 2.2.1 – 2.2.3). Over the past ten years the following trends in reported cases are notable:

    o Sex: The percentage of cases that are female increased during the 90s but since then has fluctuated between 30-39% of cases.

    o Race/ethnicity: The percentage of Hispanic cases has increased from about 25% in the late 90s to an average of 36.9% in the past four years.

    o Risk: Recent trends in risk information when adjusted for missing information indicate that about 50% of cases have a history of IDU. About 25% are associated with MSM and about 25% with heterosexual transmission.

    o Age: Trends by age group suggest a gradual increase in the age of newly diagnosed cases. While the percentage of cases in the 30-39 age group has been decreasing, the percentage of cases that are in the 50+ age group increased during the 90s and early 00s but over the past 4 years has leveled off at an average of 21.0%. This shift in age distribution could be due to delay in AIDS diagnosis because of successful treatment or a trend to older age at HIV infection.

Trends in HIV/AIDS

- Although trends have historically been presented using AIDS cases, in the future, trends in HIV infection will be better represented by the trend in newly reported HIV or AIDS cases (HIV/AIDS). HIV (not AIDS) has only been reportable in Connecticut since 2002. Table 2.2.3 and 2.2.4 show the trend since 2002 in HIV/AIDS cases. This trend will become more useful after HIV cases have been registered that were diagnosed when HIV was not reportable. Once the system is caught up, the majority of newly reported cases will also be newly diagnosed cases.

- Since 2002, 5,688 HIV/AIDS cases have been reported (an average of 1,138 per year).

- The demographic and risk profiles differ only slightly from the characteristics of AIDS and HIV cases discussed separately in other tables.

Figure 2.2.1: Trend in AIDS Cases by Sex, Connecticut, 1997 – 2006.
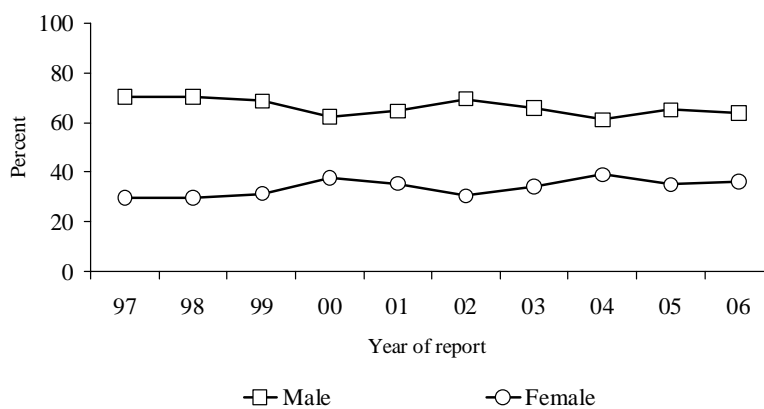

Figure 2.2.2: Trend in AIDS Cases by Race, Connecticut, 1997 – 2006.
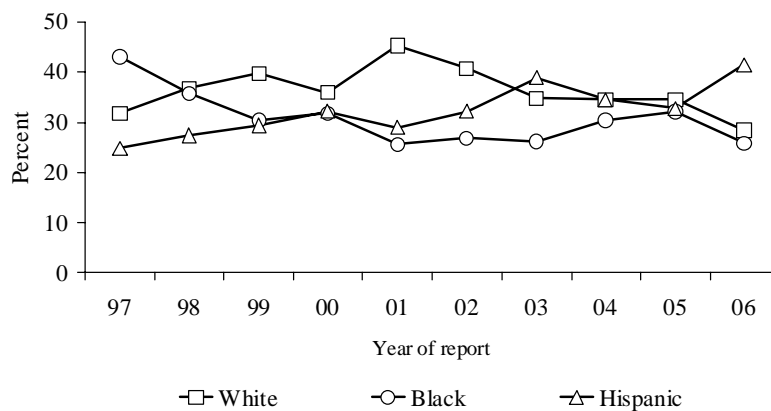
Figure 2.2.3: Trend in AIDS Cases by Risk Group, Connecticut, 1997 – 2006.
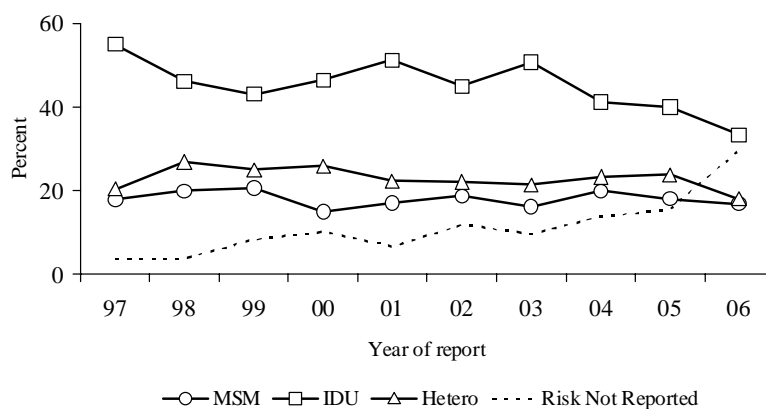
Figure 2.2.4: Trend in AIDS Cases by Age Group, Connecticut, 1997 – 2006.
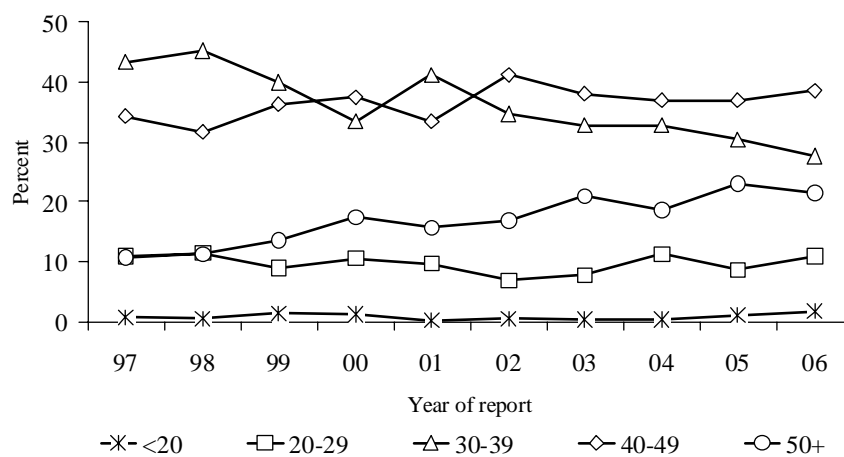
Table 2.2.1: AIDS Cases by Year of Report, Sex, Race/Ethnicity, and Risk Group, Connecticut, 1980-2006.

| Year | Total | Sex | | Race/ethnicity | | | | Risk/mode of transmission | | | | | |
		Male %	Female %	White %	Black %	Hispanic %	Other %	MSM %	IDU %	MSM/IDU %	Hetero %	Oth/unk %	Pedi %
1980-94	5,760	77.2	22.8	38.6	40.2	20.6	0.6	28.0	49.1	4.5	13.2	2.8	2.4
1995	1,521	74.1	25.9	33.9	39.6	26.0	0.5	20.4	56.0	3.2	16.0	3.3	1.1
1996	1,063	72.1	27.9	34.1	39.5	25.8	0.7	16.8	53.2	2.8	19.9	5.5	1.7
1997	1,160	70.1	29.9	32.5	42.8	24.3	0.4	17.8	55.1	2.6	20.5	3.7	0.3
1998	634	70.3	29.7	38.2	35.0	26.3	0.5	20.0	46.1	2.8	26.8	3.9	0.3
1999	576	68.4	31.6	40.8	30.2	28.1	0.9	20.8	43.1	1.4	25.0	8.3	1.4
2000	574	62.2	37.8	37.1	32.1	30.3	0.5	15.0	46.5	1.6	26.0	10.3	0.7
2001	551	64.6	35.4	47.0	25.6	26.9	0.5	17.2	51.2	2.2	22.5	6.7	0.2
2002	590	69.5	30.5	41.4	26.6	31.7	0.3	18.8	45.1	1.4	22.2	12.0	0.5
2003	692	65.9	34.1	34.8	26.2	38.9	0.1	16.3	50.6	1.6	21.5	9.7	0.3
2004	670	61.2	38.8	34.6	30.4	34.6	0.3	20.0	41.2	1.6	23.3	13.9	--
2005	583	65.2	34.8	34.5	32.1	32.8	0.7	18.2	40.0	1.5	23.8	15.4	1.0
2006	543	63.9	36.1	28.4	25.8	41.4	4.4	16.9	33.3	1.1	18.0	29.5	1.1
Total	14,917	71.8	28.2	36.9	36.4	26.1	0.7	22.1	48.8	3.1	18.2	6.5	1.4

Table 2.2.2: AIDS Cases by Year of Report, and Age at AIDS Diagnosis, Connecticut, 1980-2006.

Report year	Total	Age when diagnosed with AIDS					
		0-12 %	13-19 %	20-29 %	30-39 %	40-49 %	50+ %
1980-94	5,760	2.3	0.4	16.4	46.8	24.2	9.9
1995	1,521	1.1	0.2	12.6	48.6	28.8	8.7
1996	1,063	1.7	0.7	12.6	45.6	29.3	10.2
1997	1,160	0.2	0.5	10.9	43.3	34.3	10.8
1998	634	0.2	0.3	11.4	45.3	31.7	11.2
1999	576	0.5	0.9	8.9	39.9	36.3	13.5
2000	574	0.3	0.9	10.5	33.4	37.5	17.4
2001	551	--	0.2	9.6	41.2	33.4	15.6
2002	590	0.3	0.2	6.8	34.6	41.2	16.9
2003	692	0.3	0.1	7.8	32.8	38.0	21.0
2004	670	--	0.3	11.3	32.7	37.0	18.7
2005	583	0.9	0.2	8.7	30.4	36.9	23.0
2006	543	0.4	1.3	10.9	27.6	38.5	21.4
Total	14,917	1.2	0.4	12.8	42.5	30.4	12.7

Table 2.2.3: Connecticut HIV/AIDS Cases by Year of Report, Sex, Race/Ethnicity, and Risk, Connecticut, 2006.

Report year	Total	Sex		Race/ethnicity				Risk/mode of transmission					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/unk	Pedi
		% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total
2002	948	64.5	35.5	37.1	26.5	35.5	0.8	16.4	43.2	1.4	22.6	16.1	0.3
2003	1,027	66.4	33.6	35.1	26.2	38.7	0.1	17.4	44.9	1.7	20.9	14.8	0.3
2004	978	62.0	38.0	34.7	29.6	35.2	0.6	21.1	35.8	1.4	23.1	18.6	--
2005	1,389	62.1	37.9	32.7	30.4	36.1	0.8	18.1	40.0	1.5	25.6	14.3	0.4
2006	1,346	61.6	38.4	34.4	25.5	35.2	4.9	17.4	33.7	0.7	15.7	32.0	0.5
Total	5,688	63.1	36.9	34.6	27.7	36.1	1.6	18.0	39.2	1.3	21.5	19.6	0.3

Table 2.2.4: Connecticut HIV/AIDS Cases by Year of Report, and Age at Report, Connecticut, 2006.

Report year	Total	Age when reported					
		0-12 % of total	13-19 % of total	20-29 % of total	30-39 % of total	40-49 % of total	50+ % of total
2002	948	0.3	--	5.3	22.5	43.0	28.9
2003	1,027	0.2	--	6.2	20.9	39.1	33.5
2004	978	--	0.2	8.3	21.7	42.8	27.0
2005	1,389	0.2	0.4	8.2	23.0	38.9	29.2
2006	1,346	0.1	0.8	9.1	23.8	39.9	26.3
Total	5,688	0.2	0.3	7.6	22.5	40.6	28.9

2.3   Incidence of HIV/AIDS

- In the context of HIV/AIDS surveillance, incidence is defined as the number of HIV or AIDS cases occurring during a specified time period usually expressed as cases per 100,000 population in a particular year. The calculation of incidence rates is explained in the methods section (Appendix 1). Use of rates allows populations of different sizes to be compared. To calculate a rate the number of cases and the size of the population must be known. For some groups, such as MSM or IDU, the size of the population cannot be known and therefore rates cannot be calculated.

- Since it is usually not possible to detect HIV cases at the time of initial infection, diagnosis date is used as the earliest point at which the infection can be confirmed. Since the year of diagnosis can precede the year of report, numbers of diagnosed cases in recent years can be undercounts (Figure 2.3.1). For this reason, rates calculated in 2007 use diagnosed cases from 2003-2004.

- Table 2.3.1 shows AIDS diagnosis rates by race/ethnicity and sex. The overall rate of AIDS in Connecticut in 2003-04 was 15.1 newly diagnosed cases per 100,000 population. The rate was highest in Hispanics (58.1/100,000) and blacks (53.0/100,000). There are differences by sex, with male rates highest in all race categories where there were a significant number of cases.

- Differences in reporting rates of HIV/AIDS cases are shown in Figure 2.3.2. The rate of reported cases of HIV/AIDS in 2006 is compared for various sex and race/ethnicity groups by age group. The highest rates were in Hispanic and black males in the 40-49 age group (318-424/100,000). Among females, the highest reporting rates were also in blacks and Hispanics in the 30-49 age groups (100-150/100,000). Note that the rate in black females in the 30-39 age group exceeded the black male rate. Incidence in white males and females was comparatively low in all age groups (<25/100,000).

Figure 2.3.1: Trends in AIDS Cases, by Year of Diagnosis and Report, Connecticut, 1990-2006.
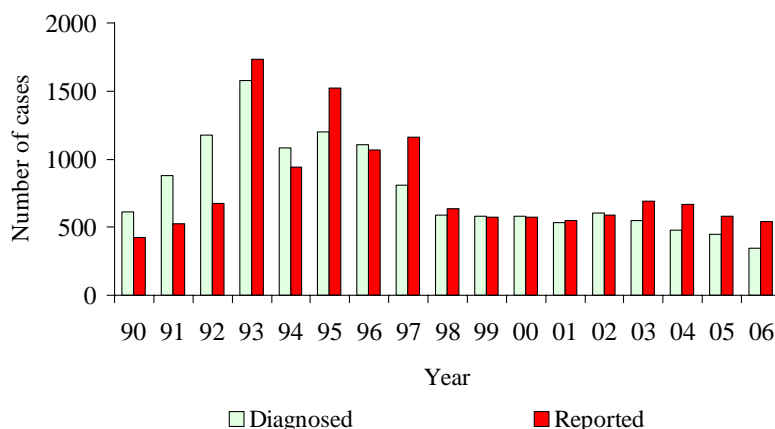
Table 2.3.1: AIDS Diagnosis and Rates per 100,000 Population, by Race/Ethnicity and Sex, Connecticut, 2003-2004.

Race/ethnicity	Males			Females			Total		
	N	%	Rate	N	%	Rate	N	%	Rate
White (non-Hispanic)	240	36.8	9.1	92	24.7	3.5	332	32.4	6.3
Black (non-Hispanic)	191	29.2	64.6	122	32.8	41.3	313	30.5	53.0
Hispanic	219	33.5	68.4	153	41.1	47.8	372	36.3	58.1
Asian/OPI[1]	2	0.3	2.5	1	0.3	1.2	3	0.3	1.8
AI/AN[2]	0	0.0	0.0	1	0.3	13.8	1	0.1	6.9
Multi-race	1	0.2	1.9	3	0.8	5.7	4	0.4	3.8
Total	653	100.0	19.2	372	100.0	10.9	1,025	100.0	15.1

[1] Other Pacific Islanders.
[2] American Indians and Alaskan Natives.

Figure 2.3.2: Reported Cases of HIV/AIDS by Sex, Race/Ethnicity, and Age at Diagnosis (per 100,000), Connecticut, 2006.
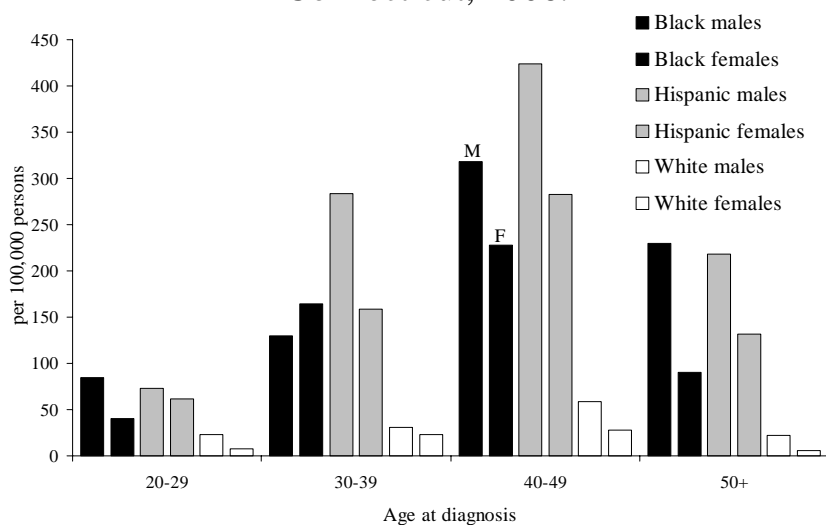
2.4 HIV/AIDS Deaths and Hospitalizations

Deaths

- There are two sources of data available concerning deaths in persons with HIV infection. The HIV/AIDS surveillance system collects information about deaths in HIV-infected people but does not collect information about cause of death. The Vital Records Section at DPH collects information about all deaths and includes primary and secondary causes. Vital Records reports deaths due to HIV/AIDS to the HIV/AIDS Surveillance Program. The Program also periodically matches the HIV/AIDS registry against the Vital Records Death registry to identify deaths in persons with HIV/AIDS from other causes.

- Since 1981, 17,478 HIV/AIDS cases have been reported and of these, 7,668 (43.9%) are known to have died (Table 2.1.1). The peak year was 1995 with 830 deaths reported. During the late 90s and early 00s, deaths leveled off with an average of 291 per year during 1998-2003.

- Figures 2.4.1 and 2.4.2 show the decrease in AIDS deaths in males and females aged 25-44 years relative to other causes of death during the 1990's when new treatments for HIV infection were introduced. However, as shown in Table 2.4.1, HIV infection is still an important cause of death in Connecticut. For example, the age-adjusted mortality rate in black males in 1999-2001 was almost twenty times higher than in white males.

Hospitalizations

- In 2004, there were 316,282 total hospitalizations for all causes in Connecticut hospitals not including those related to pregnancy and birth, with total charges of over six and a half billion dollars (www.dph.state.ct.gov).

- Table 2.4.2 shows the number of hospitalizations with HIV/AIDS (042, V08) listed as the first discharge code. Importantly, these numbers refer to hospitalization events, not to individuals. The same individual can be represented in more than one hospitalization.

- In 2004, there were 707 hospitalizations (19.5/100,000 population) where HIV/AIDS was the first discharge code. The median length of stay in the hospital was seven days and the median charge was $21,060. The total cost of the 707 hospitalizations was $26,980,866. There were 3,469 hospitalizations with HIV/AIDS in the first 10 diagnostic fields.

- Reflecting the disproportionate impact of HIV on black and Hispanic Connecticut residents, these groups have a much higher risk of HIV/AIDS hospitalization than the white population. The HIV/AIDS hospitalization rate for blacks was 18.8 times higher than for whites and the rate for Hispanics was 10.6 times higher than for whites (rates calculated as the number of discharges per 100,000 population). Men were hospitalized 1.6 times more often than females (data not shown; http://www.dph.state.ct.us/PB/HISR/HCQSAR/VitalStats/RR2004/Hosp_2004.htm). These data are for hospital discharges and individual patients can have multiple discharges during the year.

Table 2.4.1: HIV/AIDS Deaths[1,2] by
Race/Ethnicity and Sex, Connecticut, 1999-2001.

	Rank[3]	Number of deaths	AAMR[4]
Black male	4	177	46.8
Black female	8	76	15.9
Hispanic male	4	105	30.0
Hispanic female	6	47	11.3
White male	>12	106	2.4
White female	>12	54	1.2
Total	>12	593	5.6

[1] Deaths are classified according to the ICD-10 systems.

[2] DPH Vital Records.

[3] Ranks are based on the NCHS leading causes of death list.

[4] Age adjusted mortality rates (AAMR) (per 100,000) based on race and ethnicity specific populations estimates. Age-adjusted rates were calculated by the direct method using the 2000 US standard population.

Figure 2.4.1: Death Rates* for Leading Causes of Death Among MALES Aged 25-44 Years, Connecticut, 1989-1998.

*Per 100,000 population
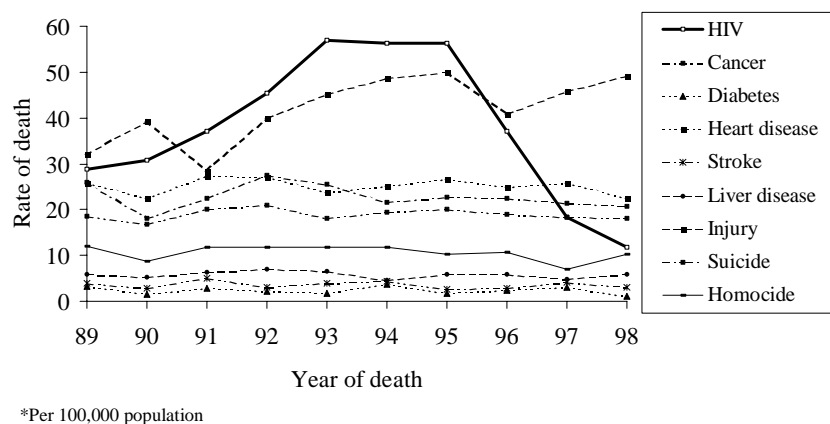
Figure 2.4.2: Death Rates* for Leading Causes of Death Among FEMALES Aged 25-44 Years, Connecticut, 1989-1998.

*Per 100,000 population
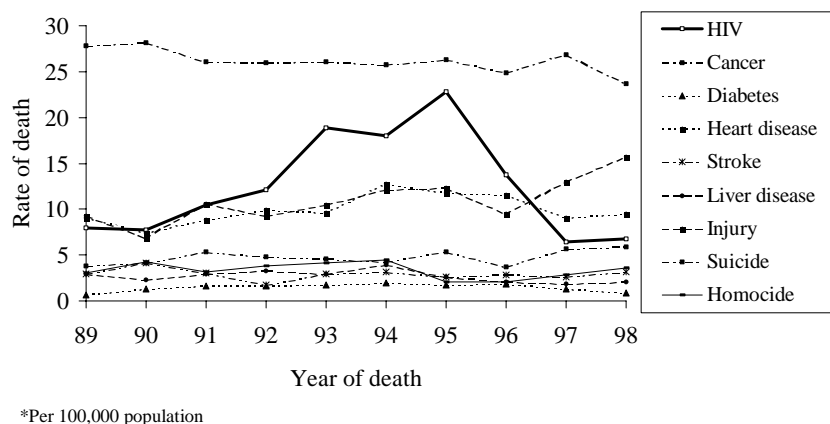
Table 2.4.2. HIV/AIDS Hospitalizations, Connecticut Residents, 2004.

Age group	Total				Male				Female			
	Number discharges[1]	Rate[2]	Median[3] stay	Median charges	Number discharges	Rate	Median stay	Median charges	Number discharges	Rate	Median stay	Median charges
0-4	--	--	--	--	--	--	--	--	--	--	--	--
5-14	--	--	5.0	$12,482	--	--	2.0	$10,182	--	--	8.0	$14,782
15-24	16	3.5	10.0	$25,189	9	3.8	10.0	$23,085	7	3.1	10.0	$32,611
25-44	399	41.0	7.0	$21,020	216	44.9	6.0	$19,999	183	37.2	7.0	$23,575
45-64	280	30.9	6.0	$20,299	195	44.4	7.0	$21,458	85	18.2	6.0	$19,119
65+	8	1.7	10.5	$43,219	-	-	6.5	$38,404	-	-	13.5	$43,219
Total[4]	707	19.5	7.0	$21,060	429	24.0	7.0	$20,797	278	15.3	7.0	$23,265

[1] Numbers of discharges represent events, not unique persons hospitalized. HIV/AIDS (042, V08) discharge based on International Classification of Diseases. First listed code.

[2] Rates are expressed as discharges per 100,000 population.

[3] Median is a statistical term meaning that half of the total is above this value and half is below.

[4] The total does not add because in the younger age groups the data is suppressed to protect confidentiality due to low numbers.

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2.5 People Living with HIV/AIDS (PLWHA) (Prevalence)

- As of December 2005, there were estimated to be 16,624 to 18,960 (midpoint 17,792) PLWHA in Connecticut (Table 2.5.1). Of these, 9,871 (50.4%) have been reported to DPH HIV/AIDS Surveillance Program. The gap is due to at least two reasons. First, CDC has estimated that 25% of PLWHA are unaware of their infection, and second, for many years AIDS was reportable but HIV (not AIDS) was not reportable (HIV was made reportable in 2002). Due to the recent implementation of HIV reporting, the PLWHA data provided here are disproportionately AIDS cases.

- In Table 2.5.2 and 2.5.3, race and risk groups are ranked by number of PLWHA in each group. Race/risk groups with IDU risk were in three of the top four groups and blacks and Hispanics were in four of the top six groups.

- Of 9,871 PLWHA, 65.8% are male and 34.2% are female (Table 2.5.4). Approximately one-third are white (35.0%), black (31.3%) and Hispanic (32.4%). The risk associated with HIV infection is known in 88% of cases. Nearly half (43.0%) are associated with IDU risk, 19.5% with MSM and 22.2% with heterosexual risk. Among males, 29.7% are associated with MSM but among non-MSM adult males where the risk is known (n=3,559), 80.0% are IDU and 20.0% are heterosexual risk. Among adult females where risk is known (n=2,880), 48.7% are IDU and 51.3% are associated with heterosexual transmission.

- Only 5.8% of PLWHA are less than 30 years of age and 18.0% are 30-39. The majority of reported cases are 40-49 (42.7%) and 50+ (33.6%) years (Table 2.5.4).

- Table 2.5.5 shows 26 cities with 50 or more cases of PLWHA. Sixteen cities have over 100 cases each and account for 80.1% of all PLWHA. Three cities, Hartford, New Haven, and Bridgeport, have over 1,000 cases each and account for 47.0% of all PLWHA. In three cities, over 50% of PLWHA are IDU: Hartford (57.4%), Windham (60.0%), and Middletown (50.7%). Notably, MSM is highest in several smaller cities that tend to have less than 100 cases: Greenwich (51.6%), Milford (45.6%), and West Hartford (41.9%).

- Figure 2.5.1 shows a comparison of the prevalence for race/ethnicity gender groups by age group per 100,000 population. The highest prevalence is in black and Hispanic males in the 40-49 age group (~3,500 per 100,000). In the 20-29 and 30-39 age groups prevalence is comparable between males and females. The male-to-female ratio increases with age group.

Figure 2.5.1: HIV/AIDS Prevalence (PLWHA) by Sex, Race/Ethnicity, and Age at Diagnosis (per 100,000), Connecticut, 2006.

- Tables 2.5.6-2.5.14 provide information about PLWHA in Connecticut counties.
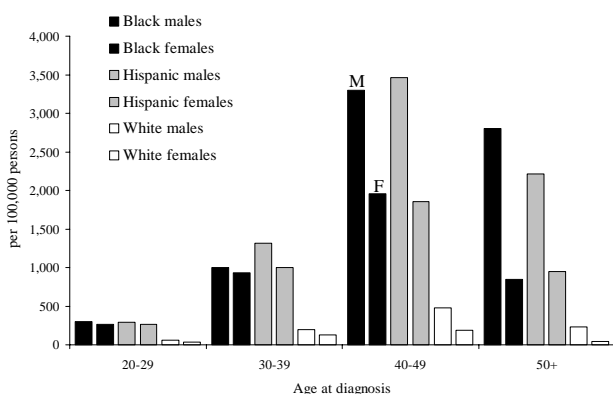
Table 2.5.1: Estimated[1] Number of People Living with HIV Infection, [2] Connecticut, 2005.

At the end of 2003, the estimated number of people infected with HIV in the US (HIV and AIDS) [3]:	1,039,000 – 1,185,000	
At the end of 2005, the reported number of PLWA in the US[3]:	437,982	
At the end of 2005, the reported number of PLWA in Connecticut:	7,028	
Percentage of people in the US living with AIDS that are in Connecticut:	(7,028/437,982) X 100 =	1.60%
Estimate of the number of people living with HIV infection in Connecticut:	Lower limit:	
	1.60% X 1,039,000 =	16,624
	Upper limit:	
	1.60% X 1,185,000 =	18,960
Midpoint:		17,792
Aware of infection[4]:	75%	13,344

[1] Estimated as recommended by *Integrated Guidelines for Developing Epidemiologic Profiles*. CDC. 2003.

[2] HIV infection includes persons with HIV and AIDS, reported and not reported.

[3] CDC. HIV/AIDS Surveillance Report 2004: 12: 1-48.

[4] Nationally, it is estimated that 25% of HIV infected persons are not aware of their infection.

Table 2.5.2: PLWHA by Race/Risk Groups,
Sorted by Risk Group, Connecticut, 2006.

Risk group	N	Rank order
Black hetero	862	5
Hispanic hetero	773	6
White hetero	524	7
Black IDU	1,477	2
Hispanic IDU	1,588	1
White IDU	1,144	4
Black MSM	316	9
Hispanic MSM	346	8
White MSM	1,237	3

Table 2.5.3: PLWHA by Race/Risk Groups,
Sorted by Rank, Connecticut, 2006.

Risk Group	N	Rank order
Hispanic IDU	1,588	1
Black IDU	1,477	2
White MSM	1,237	3
White IDU	1,144	4
Black hetero	862	5
Hispanic hetero	773	6
White hetero	524	7
Hispanic MSM	346	8
Black MSM	316	9

Table 2.5.4: PLWHA[1] by Risk/Mode of Transmission, Sex, Race/Ethnicity and Current Age, Connecticut, 2006.

| | Risk/mode of transmission | | | | | | | | | | | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | Total | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	1,926	19.5	4,248	43.0	184	1.9	2,191	22.2	1,216	12.3	106	1.1	9,871	100.0
Sex														
Male	1,926	29.7	2,846	43.8	184	2.8	713	11.0	766	11.8	58	0.9	6,493	65.8
Female	--	--	1,402	41.5	--	--	1,478	43.8	450	13.3	48	1.4	3,378	34.2
Race/ethnicity														
White	1,237	35.8	1,144	33.1	78	2.3	524	15.2	453	13.1	15	0.4	3,451	35.0
Black	318	10.3	1,477	47.9	52	1.7	862	27.9	330	10.7	47	1.5	3,086	31.3
Hispanic	346	10.8	1,588	49.6	52	1.6	773	24.1	402	12.6	42	1.3	3,203	32.4
Other	25	19.1	39	29.8	2	1.5	32	24.4	31	23.7	2	1.5	131	1.3
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	19	100.0	19	0.2
13-19	4	5.3	--	--	--	--	4	5.3	2	2.6	66	86.8	76	0.8
20-29	134	28.5	95	20.2	5	1.1	105	22.3	110	23.4	21	4.5	470	4.8
30-39	338	19.1	625	35.3	30	1.7	494	27.9	286	16.1	--	--	1,773	18.0
40-49	836	19.8	1,891	44.9	99	2.4	915	21.7	471	11.2	--	--	4,212	42.7
50+	614	18.5	1,637	49.3	50	1.5	673	20.3	347	10.4	--	--	3,321	33.6

[1] Includes people living with HIV or AIDS.

Table 2.5.5: PLWHA by City of Residence at Diagnosis, Risk, Race/Ethnicity, and Sex, Connecticut, 2006.

Residence	Total	Sex		Race/ethnicity				Risk/mode of transmission					
		Male %	Female %	White %	Black %	Hispanic %	Other %	MSM %	IDU %	MSM/IDU %	Hetero %	Oth/unk %	Pedi %
HARTFORD	1,943	66.2	33.8	15.3	32.8	51.1	0.7	10.9	57.4	2.3	19.2	9.4	0.8
NEW HAVEN	1,438	63.4	36.6	25.1	48.3	24.6	1.9	17.0	48.5	2.0	22.7	7.6	2.1
BRIDGEPORT	1,261	60.3	39.7	18.3	41.2	39.1	1.4	12.3	41.2	2.1	28.2	15.5	0.7
WATERBURY	662	60.4	39.6	31.9	26.0	41.8	0.3	14.0	49.7	2.1	20.4	12.4	1.4
STAMFORD	489	69.5	30.5	29.4	48.3	20.9	1.4	23.1	35.0	1.2	22.9	15.7	2.0
NEW BRITAIN	361	62.3	37.7	29.4	11.9	57.6	1.1	15.2	47.1	1.1	22.7	12.7	1.1
NORWALK	324	63.6	36.4	36.7	41.7	19.8	1.9	21.0	33.6	1.5	25.6	16.4	1.9
DANBURY	214	67.3	32.7	50.5	19.2	28.5	1.9	23.8	36.0	1.9	26.2	11.2	0.9
NEW LONDON	184	61.4	38.6	34.8	27.7	32.6	4.9	19.0	42.4	2.7	28.3	6.5	1.1
MERIDEN	181	63.0	37.0	36.5	12.7	49.7	1.1	21.5	35.4	1.7	26.0	14.9	0.6
E HARTFORD	172	62.2	37.8	33.7	30.8	33.7	1.7	14.5	34.3	2.9	23.3	25.0	--
WEST HAVEN	171	59.6	40.4	36.3	39.2	23.4	1.2	19.9	36.8	1.2	31.6	7.6	2.9
MIDDLETOWN	142	61.3	38.7	47.9	28.9	21.8	1.4	18.3	50.7	1.4	21.1	8.5	--
NORWICH	135	60.7	39.3	51.9	31.9	14.1	2.2	23.0	40.0	0.7	25.2	10.4	0.7
WINDHAM	125	60.0	40.0	34.4	12.0	52.0	1.6	12.8	60.0	1.6	19.2	4.8	1.6
HAMDEN	105	61.0	39.0	46.7	41.0	11.4	1.0	24.8	30.5	1.0	33.3	10.5	--
STRATFORD	86	73.3	26.7	51.2	29.1	17.4	2.3	30.2	25.6	1.2	25.6	17.4	--
MANCHESTER	78	59.0	41.0	52.6	25.6	20.5	1.3	16.7	35.9	--	26.9	20.5	--
BRISTOL	73	63.0	37.0	64.4	6.8	28.8	--	26.0	39.7	--	24.7	9.6	--
BLOOMFIELD	68	69.1	30.9	22.1	63.2	13.2	1.5	22.1	33.8	1.5	32.4	10.3	--
EAST HAVEN	66	75.8	24.2	66.7	6.1	27.3	--	30.3	34.8	1.5	15.2	18.2	--
GREENWICH	64	75.0	25.0	73.4	10.9	15.6	--	51.6	20.3	1.6	10.9	15.6	--
W HARTFORD	62	72.6	27.4	61.3	17.7	17.7	3.2	41.9	27.4	1.6	16.1	12.9	--
TORRINGTON	61	70.5	29.5	73.8	9.8	14.8	1.6	21.3	44.3	3.3	13.1	18.0	--
MILFORD	57	78.9	21.1	84.2	8.8	7.0	--	45.6	17.5	1.8	14.0	21.1	--
WALLINGFORD	50	82.0	18.0	74.0	10.0	16.0	--	38.0	28.0	4	16.0	14.0	--
All other towns	1,299	77.1	22.9	76.0	10.8	11.9	1.3	38.0	27.3	1.6	16.9	15.6	0.7
Total	9,871	65.8	34.2	35.0	31.3	32.4	1.3	19.5	43.0	1.9	22.2	12.3	1.1

Table 2.5.6: PLWHA by County at Diagnosis, Risk, Race/Ethnicity, and Sex, Connecticut, 2006.

| County | Total | Sex | | Race/ethnicity | | | | Risk/mode of transmission | | | | | |
		Male %	Female %	White %	Black %	Hispanic %	Other %	MSM %	IDU %	MSM/IDU %	Hetero %	Oth/unk %	Pedi %
HARTFORD	3,060	66.7	33.3	26.7	28.0	44.3	1.0	15.5	50.1	1.9	20.2	11.6	0.7
NEW HAVEN	2,990	64.0	36.0	36.2	34.5	28.1	1.2	20.0	43.7	1.8	22.7	10.3	1.5
FAIRFIELD	2,657	65.6	34.4	32.7	37.0	28.8	1.5	20.3	35.8	1.8	25.0	15.9	1.1
NEW LONDON	494	65.8	34.2	50.4	24.9	20.9	3.8	27.7	36.2	2.2	23.7	9.3	0.8
MIDDLESEX	207	64.7	35.3	59.4	22.2	17.4	1.0	26.6	43.5	1.0	18.4	10.6	--
WINDHAM	185	65.9	34.1	48.6	10.8	39.5	1.1	17.3	53.5	1.1	18.9	7.6	1.6
LITCHFIELD	174	76.4	23.6	80.5	8.6	10.3	0.6	31.6	33.9	2.9	12.1	19.0	0.6
TOLLAND	104	78.8	21.2	78.8	10.6	9.6	1.0	35.6	30.8	1.0	19.2	13.5	--
Total	9,871	65.8	34.2	35.0	31.3	32.4	1.3	19.5	43.0	1.9	22.2	12.3	1.1

Table 2.5.7: PLWHA, <u>Fairfield County</u>, by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

| | \multicolumn{12}{c}{Risk/mode of transmission} | | | | | | | | | | | | Total |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	539	20.3	951	35.8	49	1.8	665	25.0	423	15.9	30	1.1	2,657	100.0
Sex														
Male	539	30.9	615	35.3	49	2.8	257	14.8	261	15.0	21	1.2	1,742	65.6
Female	--	--	336	36.7	--	--	408	44.6	162	17.7	9	1.0	915	34.4
Race/ethnicity														
White	319	36.7	255	29.3	20	2.3	127	14.6	143	16.4	6	0.7	870	32.7
Black	95	9.7	392	39.9	17	1.7	319	32.5	145	14.8	14	1.4	982	37.0
Hispanic	121	15.8	294	38.4	10	1.3	207	27.0	124	16.2	10	1.3	766	28.8
Other	4	10.3	10	25.6	2	5.1	12	30.8	11	28.2	--	--	39	1.5
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	6	100.0	6	0.2
13-19	--	--	--	--	--	--	--	--	2	11.1	16	88.9	18	0.7
20-29	44	33.8	18	13.8	1	0.8	30	23.1	29	22.3	8	6.2	130	4.9
30-39	90	19.7	129	28.2	6	1.3	147	32.1	86	18.8	--	--	458	17.2
40-49	226	20.5	408	37.1	25	2.3	274	24.9	168	15.3	--	--	1,101	41.4
50+	179	19.0	396	41.9	17	1.8	214	22.7	138	14.6	--	--	944	35.5

Table 2.5.8: PLWHA in <u>Hartford County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | Total | |
| | Risk/mode of transmission | | | | | | | | | | | | | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	474	15.5	1,532	50.1	59	1.9	617	20.2	356	11.6	22	0.7	3,060	100.0
Sex														
Male	474	23.2	1,073	52.6	59	2.9	198	9.7	227	11.1	10	0.5	2,041	66.7
Female	--	--	459	45.0	--	--	419	41.1	129	12.7	12	1.2	1,019	33.3
Race/ethnicity														
White	280	34.3	280	34.3	15	1.8	121	14.8	116	14.2	4	0.5	816	26.7
Black	89	10.4	457	53.3	16	1.9	202	23.6	88	10.3	5	0.6	857	28.0
Hispanic	100	7.4	786	58.0	28	2.1	288	21.2	141	10.4	13	1.0	1,356	44.3
Other	5	16.1	9	29.0	--	--	6	19.4	11	35.5	--	--	31	1.0
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	5	100.0	5	0.2
13-19	2	11.1	--	--	--	--	2	11.1	--	--	14	77.8	18	0.6
20-29	28	19.4	36	25.0	3	2.1	34	23.6	40	27.8	3	2.1	144	4.7
30-39	100	17.5	229	40.0	9	1.6	148	25.8	87	15.2	--	--	573	18.7
40-49	195	14.9	706	53.9	34	2.6	234	17.8	142	10.8	--	--	1,311	42.8
50+	149	14.8	561	55.6	13	1.3	199	19.7	87	8.6	--	--	1,009	33.0

Table 2.5.9: PLWHA in <u>Litchfield County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

| | Risk/mode of transmission | | | | | | | | | | | | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | Total | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	55	31.6	59	33.9	5	2.9	21	12.1	33	19.0	1	0.6	174	100.0
Sex														
Male	55	41.4	40	30.1	5	3.8	4	3.0	28	21.1	1	0.8	133	76.4
Female	--	--	19	46.3	--	--	17	41.5	5	12.2	--	--	41	23.6
Race/ethnicity														
White	50	35.7	41	29.3	4	2.9	16	11.4	28	20.0	1	0.7	140	80.5
Black	2	13.3	9	60.0	1	6.7	1	6.7	2	13.3	--	--	15	8.6
Hispanic	2	11.1	9	50.0	--	--	4	22.2	3	16.7	--	--	18	10.3
Other	1	100.0	--	--	--	--	--	--	--	--	--	--	1	0.6
Current age[1]														
0-12	--	--	--	--	--	--	--	--	--	--	1	100.0	1	0.6
20-29	1	33.3	1	33.3	--	--	--	--	1	33.3	--	--	3	1.7
30-39	6	24.0	9	36.0	2	8.0	5	20.0	3	12.0	--	--	25	14.4
40-49	25	33.3	25	33.3	1	1.3	10	13.3	14	18.7	--	--	75	43.1
50+	23	32.9	24	34.3	2	2.9	6	8.6	15	21.4	--	--	70	40.2

[1]If an age group is not shown, there were no cases in that age group.

Table 2.5.10: PLWHA in <u>Middlesex County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

						Risk/mode of transmission							
	MSM		IDU		MSM/IDU		Hetero		Oth/unk		Total	
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	55	26.6	90	43.5	2	1.0	38	18.4	22	10.6	207	100.0
Sex												
Male	55	41.0	54	40.3	2	1.5	9	6.7	14	10.4	134	64.7
Female	--	--	36	49.3	--	--	29	39.7	8	11.0	73	35.3
Race/ethnicity												
White	43	35.0	48	39.0	1	0.8	13	10.6	18	14.6	123	59.4
Black	7	15.2	23	50.0	1	2.2	14	30.4	1	2.2	46	22.2
Hispanic	5	13.9	17	47.2	--	--	11	30.6	3	8.3	36	17.4
Other	--	--	2	100.0	--	--	--	--	--	--	2	1.0
Current age[1]												
20-29	6	54.5	3	27.3	--	--	2	18.2	--	--	11	5.3
30-39	8	25.0	10	31.3	--	--	9	28.1	5	15.6	32	15.5
40-49	21	22.3	43	45.7	1	1.1	18	19.1	11	11.7	94	45.4
50+	20	28.6	34	48.6	1	1.4	9	12.9	6	8.6	70	33.8

[1]If an age group is not shown, there were no cases in that age group.

Table 2.5.11: PLWHA in <u>New Haven County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

	Risk/mode of transmission													Total
	MSM		IDU		MSM/IDU		Hetero		Oth/unk		Pedi			
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	597	20.0	1,306	43.7	55	1.8	678	22.7	308	10.3	46	1.5	2,990	100.0
Sex														
Male	597	31.2	864	45.1	55	2.9	190	9.9	188	9.8	20	1.0	1,914	64.0
Female	--	--	442	41.1	--	--	488	45.4	120	11.2	26	2.4	1,076	36.0
Race/ethnicity														
White	378	35.0	387	35.8	27	2.5	176	16.3	110	10.2	3	0.3	1,081	36.2
Black	104	10.1	526	51.0	15	1.5	281	27.2	80	7.8	26	2.5	1,032	34.5
Hispanic	104	12.4	381	45.3	13	1.5	216	25.7	112	13.3	15	1.8	841	28.1
Other	11	30.6	12	33.3	--	--	5	13.9	6	16.7	2	5.6	36	1.2
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	6	100.0	6	0.2
13-19	2	5.7	--	--	--	--	1	2.9	--	--	32	91.4	35	1.2
20-29	42	29.4	29	20.3	1	0.7	33	23.1	30	21.0	8	5.6	143	4.8
30-39	102	18.4	206	37.1	9	1.6	147	26.5	91	16.4	--	--	555	18.6
40-49	264	20.7	573	44.9	31	2.4	300	23.5	108	8.5	--	--	1,276	42.7
50+	187	19.2	498	51.1	14	1.4	197	20.2	79	8.1	--	--	975	32.6

Table 2.5.12: PLWHA in <u>New London County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

| | \multicolumn{12}{c}{Risk/mode of transmission} | | | | | | | | | | | Total | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	137	27.7	179	36.2	11	2.2	117	23.7	46	9.3	4	0.8	494	100.0
Sex														
Male	137	42.2	108	33.2	11	3.4	38	11.7	28	8.6	3	0.9	325	65.8
Female	--	--	71	42.0	--	--	79	46.7	18	10.7	1	0.6	169	34.2
Race/ethnicity														
White	110	44.2	75	30.1	9	3.6	37	14.9	17	6.8	1	0.4	249	50.4
Black	14	11.4	55	44.7	2	1.6	38	30.9	13	10.6	1	0.8	123	24.9
Hispanic	9	8.7	44	42.7	--	--	34	33.0	14	13.6	2	1.9	103	20.9
Other	4	21.1	5	26.3	--	--	8	42.1	2	10.5	--	--	19	3.8
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	1	100.0	1	0.2
13-19	--	--	--	--	--	--	--	--	--	--	3	100.0	3	0.6
20-29	9	40.9	3	13.6	--	--	4	18.2	6	27.3	--	--	22	4.5
30-39	22	25.0	25	28.4	3	3.4	28	31.8	10	11.4	--	--	88	17.8
40-49	68	30.9	75	34.1	6	2.7	53	24.1	18	8.2	--	--	220	44.5
50+	38	23.8	76	47.5	2	1.3	32	20.0	12	7.5	--	--	160	32.4

Table 2.5.13: PLWHA in <u>Tolland County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

											Total	
						Risk/mode of transmission						
	MSM		IDU		MSM/IDU		Hetero		Oth/unk			
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	37	35.6	32	30.8	1	1.0	20	19.2	14	13.5	104	100.0
Sex												
Male	37	45.1	26	31.7	1	1.2	6	7.3	12	14.6	82	78.8
Female	--	--	6	27.3	--	--	14	63.6	2	9.1	22	21.2
Race/ethnicity												
White	36	43.9	20	24.4	1	1.2	14	17.1	11	13.4	82	78.8
Black	1	9.1	5	45.5	--	--	4	36.4	1	9.1	11	10.6
Hispanic	--	--	7	70.0	--	--	1	10.0	2	20.0	10	9.6
Other	--	--	--	--	--	--	1	100.0	--	--	1	1.0
Current age[1]												
20-29	1	50.0	1	50.0	--	--	--	--	--	--	2	1.9
30-39	6	40.0	3	20.0	--	--	4	26.7	2	13.3	15	14.4
40-49	18	36.0	14	28.0	--	--	12	24.0	6	12.0	50	48.1
50+	12	32.4	14	37.8	1	2.7	4	10.8	6	16.2	37	35.6

[1]If an age group is not shown, there were no cases in that age group.

Table 2.5.14: PLWHA in <u>Windham County</u> by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

| | Risk/mode of transmission | | | | | | | | | | | | Total | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	32	17.3	99	53.5	2	1.1	35	18.9	14	7.6	3	1.6	185	100.0
Sex														
Male	32	26.2	66	54.1	2	1.6	11	9.0	8	6.6	3	2.5	122	65.9
Female	--	--	33	52.4	--	--	24	38.1	6	9.5	--	--	63	34.1
Race/ethnicity														
White	21	23.3	38	42.2	1	1.1	20	22.2	10	11.1	--	--	90	48.6
Black	6	30.0	10	50.0	--	--	3	15.0	--	--	1	5.0	20	10.8
Hispanic	5	6.8	50	68.5	1	1.4	12	16.4	3	4.1	2	2.7	73	39.5
Other	--	--	1	50.0	--	--	--	--	1	50.0	--	--	2	1.1
Current age[1]														
13-19	--	--	--	--	--	--	1	50.0	--	--	1	50.0	2	1.1
20-29	3	20.0	4	26.7	--	--	2	13.3	4	26.7	2	13.3	15	8.1
30-39	4	14.8	14	51.9	1	3.7	6	22.2	2	7.4	--	--	27	14.6
40-49	19	22.4	47	55.3	1	1.2	14	16.5	4	4.7	--	--	85	45.9
50+	6	10.7	34	60.7	--	--	12	21.4	4	7.1	--	--	56	30.3

[1]If an age group is not shown, there were no cases in that age group.

2.6   HIV Surveillance

- HIV infection in adults was made reportable to DPH in January 2002 by name with a code option (physicians could elect to report HIV cases to DPH as a code instead of a patient name). The code option was not in accordance with national recommendations making Connecticut HIV cases un-acceptable to the Centers for Disease Control and Prevention (CDC). This meant that Connecticut HIV cases could not be reported to the national system. De-identified AIDS cases have been reported to CDC since 1981. In 2005, the code option was removed and DPH initiated reporting of de-identified HIV cases to CDC.

- Additional information about public health reporting, confidentiality protections, and uses of surveillance data at the national and state level can be found in Appendix 1.

- HIV viral load test results were added to DPH reporting requirements in 2006. Cases reported based on viral load tests may not have been recently diagnosed and may represent HIV cases diagnosed before HIV was made reportable in 2002.

- HIV cases as shown in Table 2.6.1 are cases that have not progressed to AIDS. Once HIV cases meet the AIDS case definition, they are re-reported as AIDS cases and removed from HIV analysis. Of the 431 HIV cases reported in 2002, 63.8% have been re-reported as AIDS cases or have died.

- During 2002-2006, 2,622 HIV cases were reported that were still HIV (not AIDS) at the end of 2006 (Table 2.6.1):

    o Sex: 60.8% were male and 39.2% were female.

    o Race/ethnicity: 34.2% were white, 27.2% were black, and 36.3% were Hispanic.

    o Risk: The pattern of risk is similar to PLWHA with 18% MSM, 35.3% IDU, and 21.0% heterosexual, and 24.2% unknown. MSM tended to be white (55.8%) while IDU tended to be Hispanic (43.6%).

    o Age: Only 9 (0.3%) cases have been reported in the 13-19 age group with 660 (25.2%) HIV cases in the 20-29 age group. This varied by race/ethnicity with Hispanics tending to be younger. Among Hispanics 26.4% of males and 33.1% of females were in the 20-29 age group.

- *Comparison of HIV and AIDS:* HIV cases reported in 2006 are compared with AIDS cases reported in 2006 in Table 2.6.1. HIV cases were slightly more likely to be female (39.4% vs. 36.1%) and younger (HIV: 25.6% 20-29 and 11.3% 50+ vs. AIDS: 10.9% 20-29 and 21.4% 50+).

- Additional tables describing cumulative reported HIV cases can be found on the DPH website (www.dph.ct.gov).

Table 2.6.1: Comparison of HIV[1,2] and AIDS Cases by Sex, Race/Ethnicity, Age Group, and Risk Group, Connecticut, 2006.

| | Percentage | | | |
Characteristics	2006 HIV	Total HIV	2006 AIDS	Total AIDS
Sex				
Male	60.6	60.8	63.9	71.8
Female	39.4	39.2	36.1	28.2
Race/ethnicity				
White	36.9	34.2	28.4	36.9
Black	26.0	27.2	25.8	36.4
Hispanic	32.5	36.3	41.4	26.1
Other[3]	4.5	2.3	4.4	0.7
Age				
0-12 years[4]	0.3	0.4	0.4	1.2
13-19	0.5	0.3	1.3	0.4
20-29	25.6	25.2	10.9	12.8
30-39	34.3	35.2	27.6	42.5
40-49	27.9	27.8	38.5	30.4
50 and over	11.3	11.1	21.4	12.7
Risk mode				
MSM	17.5	18.0	16.9	22.1
IDU	34.8	35.3	33.3	48.8
MSM/IDU	0.8	1.1	1.1	3.1
Hetero	15.1	21.0	18.0	18.2
Other/risk not reported	31.2	24.0	29.5	5.5
Total	926	2,622	543	14,917

[1] A person with HIV infection who has not developed AIDS.

[2] HIV infection became a reportable disease in Connecticut on January 1, 2002.

[3] "Other" race combines the Asian, American Indian, other and unknown race categories. These have been combined for the reason of individual confidentiality.

[4] Age when the case was reported to DPH.

2.7   HIV/AIDS in Children and Adolescents

- Nationally and in Connecticut, the rate of perinatal HIV infection has decreased by over 80% since 1993. This is due to prenatal HIV testing, use of antiretroviral treatment, obstetric procedures limiting newborn exposure to blood, and the recommendation against breastfeeding. Table 2.7.1 shows a trend in the number of HIV exposures at childbirth and the proportion of children who are infected.

- In Connecticut, legislation was enacted in 1999 mandating maternal HIV status be known at delivery, either through testing the mother during prenatal care or labor, or the newborn. Prenatal HIV testing rates increased dramatically from 28% to over 90% in the months following implementation.

- Since 1981, 288 children (<13 years of age) have been reported with HIV/AIDS. Of these, 94.4% have been due to perinatal exposure.

- Of the 95 reported PLWHA below the age of 20, 85 (89.5%) have a history of exposure to HIV at delivery, 4 (4.2%) are MSM, 4 (4.2%) are heterosexual, and 2 (2.1%) have unknown risk (see Table 2.5.4 on page 32).

Table 2.7.1: Trends in Perinatal Exposure to HIV, by Year of Birth and HIV Status of the Child (as of December 2006), Connecticut, 1995-2006.

| | Current HIV status | | | | | | | | | |
| | HIV positive | | HIV negative | | HIV pending | | Unknown[1] | | Total | |
Birth year	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
1995	9	11.8	59	77.6	0	0	8	10.5	76	10.3
1996	5	7.5	56	83.6	1	1.5	5	7.5	67	9.0
1997	3	4.4	59	86.8	2	2.9	4	5.9	68	9.2
1998	1	1.6	53	84.1	6	9.5	3	4.8	63	8.5
1999	5	7.1	64	91.4	0	0	1	1.4	70	9.4
2000	1	1.4	72	97.3	0	0	1	1.4	74	10.0
2001	3	4.5	59	89.4	1	1.5	3	4.5	66	8.9
2002	0	0	55	87.3	0	0	8	12.7	63	8.5
2003	0	0	38	76.0	0	0	12	24.0	50	6.7
2004	0	0	50	92.6	1	1.9	3	5.6	54	7.3
2005	1	2.0	42	84.0	0	0	7	14.0	50	6.7
2006	0	0	15	37.5	0	0	25	62.5	40	5.4
Total	28	3.8	622	83.9	11	1.5	80	10.8	741	100.0

[1]Unknown status includes cases lost to follow-up, dead, or moved out-of-state.

2.8 Reason for Testing in Newly Diagnosed HIV Cases

- The HIV/AIDS Surveillance Program modified the confidential case report form used to collect information about new HIV cases to include test history information including a question about why a person was tested. HIV cases newly diagnosed after February 2005 were reported using this form. Information about test history has been collected for 415 (50.7%) of the 818 newly diagnosed HIV cases that have been reported.

- As shown in Table 2.8.1, almost half (46.0%) of new cases were tested as a result of exposure ("worried that in the past 6 months they might have been exposed to HIV") and a 32.0% were exhibiting symptoms indicative of HIV infection or their physician had other reasons to suspect HIV infection. 6.5% were tested at an STD clinic or currently had an STD. Cases can have more than one reason for testing.

- Relatively few recently diagnosed cases were tested because they test regularly (9.2%), or as a result of a provider recommendation (3.9%).

Table 2.8.1: Reason for HIV Testing[1] in Newly Diagnosed HIV Cases, Connecticut, 2005-2006.

	N	% of responses[2]	% of cases[3]
Number newly reported with HIV diagnosis during 2005-2006	818		
Number of case report forms with completed test history questions	415	50.7%	
Reasons for HIV testing			
Exposure	191	34.6%	46.0%
Symptoms or doctor suspects HIV	133	24.1%	32.0%
Just checking to confirm still negative	103	18.7%	24.8%
Tests regularly	38	6.9%	9.2%
Current STD or STD screening	27	4.9%	6.5%
Required (drug rehab or blood donation)	24	4.3%	5.8%
Provider recommended	16	2.9%	3.9%
Prenatal/perintal	15	2.7%	3.6%
Immigration screen	5	0.9%	1.2%
	552	100.0%	133.0%

[1] 'Reason for HIV testing' was added to the HIV/AIDS case report form in April 2005 as part of routine HIV/AIDS surveillance for newly diagnosed cases.

[2] Individual cases could have more than one reason for testing. The 415 individual cases gave 552 reasons for testing. 'Percentage of responses' refers to the percentage of all reasons given for testing.

[3] 'Percentage of cases' refers to the percentage of HIV-positive individuals who chose a specific reason.

2.9   HIV Testing at Publicly-Funded Counseling and Testing Sites (CTS)

- The Department of Public Health supports many local HIV counseling and testing sites. These sites are for persons at risk for HIV infection, especially those who do not have private insurance. DPH staff train counselors and the tests are done at the DPH laboratory. Strict confidentiality is maintained and some sites offer anonymous testing.

- Since 1986, DPH has funded HIV counseling and testing sites throughout Connecticut. The objectives of this program:
  - Identify individuals with HIV infection for case management;
  - Provide knowledge and tools in order to change HIV risk behaviors;
  - Provide training and continuing education options to counselors funded through DPH and insure quality HIV counseling services;
  - Identify HIV-positive individuals and offer partner notification services;

- HIV counseling and testing data collection and analyses are used to monitor the extent to which these objectives are achieved.

- HIV testing is offered free of charge. Anonymous testing is also available in some sites.

HIV counseling and testing data for 2006 (Table 2.9.1)

- In 2006, 21,147 CTS clients received counseling with 19,683 HIV tests conducted and 150 (0.8%) confirmed positive.

- In 2006, 66.5% of CTS clients were male, 34.2% Hispanic (can be of any race), 40.6% white, and 31.1% black. The majority of clients were classified as heterosexual with no other risk factor (71.3%). Other client risks included sex while using drugs as a risk (43.4%), heterosexual IDU (14.2%), and MSM (7.2%).

- Of the 150 clients who were confirmed to have tested positive in 2006, 82.7% were male, 31.3% Hispanic (can be of any race), 31.3% white, 34.0% black, and for 34.7% race was other or not collected. The risk distribution of the positives included: 30.0% MSM, 19.3% heterosexual IDU, 53.3% sex while using drugs, and 43.3% heterosexual.

- There were 1,536 anonymous testers in 2006. Of these, 25 were positive on the first test but only 6 (0.4%) had a confirmatory test and were confirmed positive.

- Data from prior years can be found at the DPH website (www.dph.state.ct.us).

Table 2.9.1: HIV Testing at Counseling and Testing Sites, Connecticut, 2006.

Client characteristics	Number of counseled clients	Number of HIV tests	Number of HIV positives	Percent HIV positive[1]	Percent of HIV positives[2]
Sex					
Male	14,055	12,934	123	1.0%	82.7%
Female	7,092	6,749	27	0.4%	18.0%
Race/ethnicity					
White	8,595	8,184	47	0.6%	31.3%
Black	6,573	5,992	51	0.9%	34.0%
Other	5,698	5,292	52	1.0%	34.7%
Hispanic (All Races)	7,231	6,787	47	0.7%	31.3%
Age group					
Under 13	1	1	0	0.0%	0.0%
13-19	2,142	2,017	0	0.0%	0.0%
20-29	7,341	6,809	40	0.6%	26.7%
30-39	5,578	5,168	63	1.2%	42.0%
40-49	3,772	3,533	32	0.9%	21.3%
50 and over	1,286	1,210	10	0.8%	6.7%
Age Unknown	964	945	5	0.5%	3.3%
Risk					
MSM IDU	74	70	5	7.1%	3.3%
MSM	1,521	1,462	45	3.1%	30.0%
Heterosexual IDU	3,001	2,761	29	1.1%	19.3%
Sex Partner at Risk	No Data	No Data	No Data	No Data	No Data
STD Diagnosis	No Data	No Data	No Data	No Data	No Data
Sex for Drugs/Money	No Data	No Data	No Data	No Data	No Data
Sex While Using Drugs	9,173	8,488	80	0.9%	53.3%
HEM/Blood Recipient	No Data	No Data	No Data	No Data	No Data
Victim of Sexual Assault	No Data	No Data	No Data	No Data	No Data
Health Care Exposure	No Data	No Data	No Data	No Data	No Data
No Acknowledged Risk	3,344	3,024	16	0.5%	10.7%
Heterosexual, No Other Risk	15,074	14,092	65	0.5%	43.3%
Total	21,147	19,683	150	0.8%	100.0%

[1] Percent HIV positive is the percent of those tested in this category that were found to be HIV positive.

[2] Percent of HIV positives is the percent of all HIV positives that are in this category.

[3] Race/ethnicity category does not add to 100% because more than one option can be chosen.

[4] Risk categories do not add to 100% because more than one option can be chosen.

Section 3:   Community Planning Group Regions

- There are seven CPG regions in Connecticut; six are composed of one or more counties and one is composed of the Department of Corrections (DOC) (Figure 3.1).

- Table 3.1 compares CPG regions by PLWHA.

    o The majority (79.3%) of PLWHA live in three CPG regions: SC, NC, SW.

    o IDU is an important risk group in all CPG regions (80.0% of PLWHA in DOC to 30.9% in SW). In two regions, NW and SE, MSM and IDU are approximately equal. The number of PLWHA in these regions is small, with a total of 593 (6.0% of all PLWHA). The NE region also has a small number of PLWHA (n=262) but 41.2% are IDU and only 26.0% are MSM.

    o Four CPG regions have over 1,000 PLWA: SC, NC, SW, DOC. The remaining regions include only 855 (8.7%) PLWHA.

    o 1,193 PLWHA were in DOC when reported as HIV/AIDS cases (Table 3.2). As expected, most cases (80.0%) are associated with IDU with minor populations of MSM (3.8%) and heterosexual (6.9%). These cases are also 77.8% male, 44.6% black, 35.1% Hispanic and 80.2% are 40 years of age or older.

Figure 3.1: Community Planning Regions, Connecticut, 2006.

North-West (NW)   North-Central (NC)   North-East (NE)

Litchfield   Hartford   Tolland   Windham

Middlesex   South-East (SE)

South-Central (SC)   New London

South-West (SW)   New Haven

Fairfield

Department of Corrections
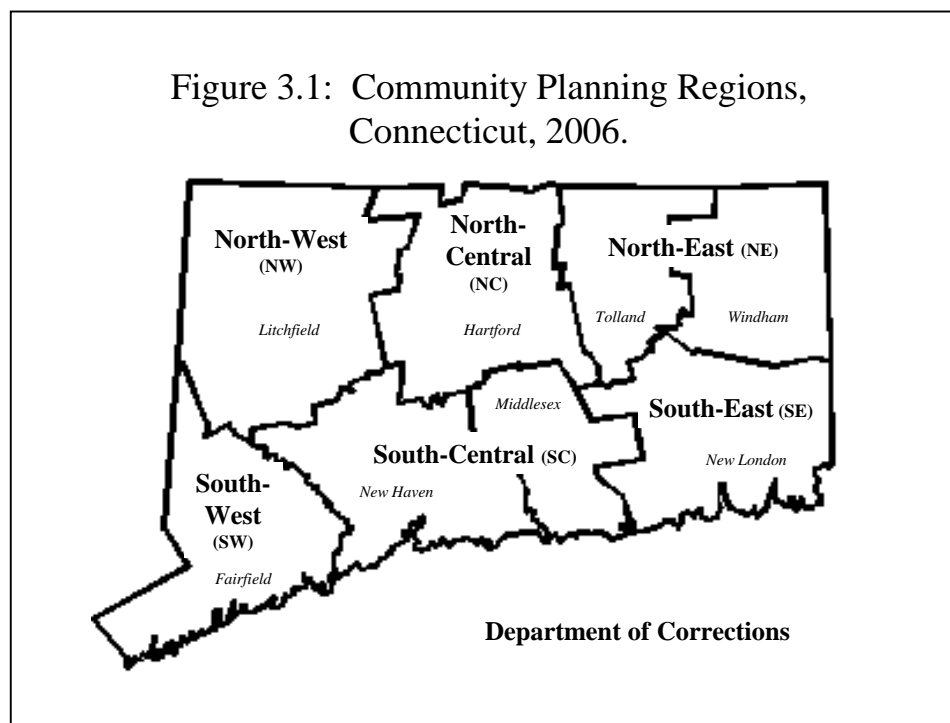
Table 3.1: PLWHA by CPG Region at Diagnosis, Risk, Race/Ethnicity, and Sex, Connecticut, 2006.

| | | Sex | | Race/ethnicity | | | | Risk/mode of transmission | | | | | |
| | | Male | Female | White | Black | Hispanic | Other | MSM | IDU | MSM/IDU | Hetero | Oth/unk | Pedi |
CPG Region	Total	%	%	%	%	%	%	%	%	%	%	%	%
South-Central	2,835	62.3	37.7	39.6	31.5	27.6	1.3	22.4	39.2	1.6	24.3	11.0	1.5
North-Central	2,612	64.1	35.9	28.8	26.6	43.4	1.1	17.8	44.3	2.0	22.5	12.6	0.8
South-West	2,376	64.6	35.4	34.1	35.1	29.3	1.6	22.1	30.9	1.6	27.1	17.0	1.3
DOC	1,193	77.8	22.2	20.0	44.6	35.1	0.3	3.8	80.0	3.0	6.9	6.0	0.3
South-East	435	66.0	34.0	53.3	21.4	20.9	4.4	30.8	31.0	2.1	26.0	9.2	0.9
North-East	262	69.1	30.9	62.6	11.1	25.2	1.1	26.0	41.2	0.4	20.6	10.7	1.1
North-West	158	75.9	24.1	82.3	7.6	9.5	0.6	34.2	31.0	1.9	12.7	19.6	0.6
Total	9,871	65.8	34.2	35.0	31.3	32.4	1.3	19.5	43.0	1.9	22.2	12.3	1.1

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Table 3.2: PLWHA, Dept of Correction by Risk, Sex, Race/Ethnicity, and Age Group, Connecticut, 2006.

| | | | | | | Risk/mode of transmission | | | | | | | | | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | Total | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	45	3.8	954	80.0	36	3.0	82	6.9	72	6.0	4	0.3	1,193	100.0
Sex														
Male	45	4.8	736	79.3	36	3.9	52	5.6	56	6.0	3	0.3	928	77.8
Female	--	--	218	82.3	--	--	30	11.3	16	6.0	1	0.4	265	22.2
Race/ethnicity														
White	21	8.8	192	80.3	8	3.3	9	3.8	9	3.8	--	--	239	20.0
Black	17	3.2	397	74.6	17	3.2	54	10.2	44	8.3	3	0.6	532	44.6
Hispanic	7	1.7	363	86.6	10	2.4	19	4.5	19	4.5	1	0.2	419	35.1
Other	--	--	2	66.7	1	33.3	--	--	--	--	--	--	3	0.3
Current age														
13-19	--	--	--	--	--	--	--	--	--	--	3	100.0	3	0.3
20-29	6	22.2	11	40.7	1	3.7	2	7.4	6	22.2	1	3.7	27	2.3
30-39	11	5.3	149	72.3	2	1.0	23	11.2	21	10.2	--	--	206	17.3
40-49	22	3.8	467	80.2	22	3.8	41	7.0	30	5.2	--	--	582	48.8
50+	6	1.6	327	87.2	11	2.9	16	4.3	15	4.0	--	--	375	31.4

Section 4:   Ryan White Transitional Grant Areas

- In 2006, the Ryan White HIV Treatment Modernization Act was enacted. According to criteria provided in the new legislation neither the New Haven nor the Hartford EMAs had sufficient AIDS cases to continue as EMAs and were reclassified as Transitional Grant Areas (TGAs).

- Table 4.1 shows the 2005 PLWHA data reported by CDC to HRSA for use in the 2007 funding allocation. In 2007, for the first time, CDC reported to HRSA PLWHA data based on actual surveillance numbers without the use of estimates. CDC used Connecticut data reported through the end of 2005 for the 2007 allocation.

- The Hartford TGA is composed of Hartford, Middlesex, and Tolland Counties. The New Haven TGA is composed of New Haven and Fairfield Counties (Figure 4.1).

- Of the 14,917 cumulative AIDS cases reported in Connecticut, 13,744 (92.1%) were residents of one of the two TGAs (www.dph.state.ct.us). Of the 9,871 PLWHA in Connecticut at the end of 2006, 9,017 (91.3%) lived in one of the two TGAs.

- Additional data tables for the Hartford and New Haven TGAs (trends in AIDS case reporting, cumulative AIDS cases, HIV (not AIDS)) can be found on the DPH web site (www.dph.state.ct.us).

Hartford TGA

- Cumulative reported AIDS cases: 5,203 (73.4% male, 32.0% white, 32.7% black, 34.6% Hispanic, 20.4% MSM, 53.4% IDU, and 16.0% heterosexual risk).

- During the most recent five-year period, 2002-2006, 1,112 AIDS cases were reported with an average of 222 cases reported each year ranging from 181 to 277.

- During 2002-2006, 861 HIV (not AIDS) cases were reported.

- PLWHA: 3,370 (34.1% of PLWHA in Connecticut (Figure 4.2, Table 4.2); 16.8% MSM, 49.1% IDU, 20.0% heterosexual exposure, 41.6% Hispanic, 27.1% black, and 30.3% white).

New Haven TGA

- Cumulative reported AIDS cases: 8,451 (70.5% male, 36.4% white, 40.8% black, 22.1% Hispanic, 22.0% MSM, 46.9% IDU, 19.7% heterosexual risk).

- During the most recent five-year period, 2002-2006, 1,699 AIDS cases were reported with an average of 340 cases reported each year ranging from 312 to 361.

- During 2002-2006, 1,513 HIV (not AIDS) cases were reported.

- PLWHA: 5,647 (57.2% of PLWHA in Connecticut (Figure 4.2; Table 4.2); 20.1% MSM, 40.0% IDU, 23.8% heterosexual exposure, 28.5% Hispanic, 35.7% black, and 34.5% white).

Table 4.1: People Living With HIV/AIDS in Hartford and New Haven TGA[1] and Connecticut as Reported to HRSA by CDC Using 2005 Yearend Data for Use in *The Ryan White HIV Treatment Modernization Act of 2006* Funding Allocation in FY2007.

| | TGA | | |
Data categories	Hartford[2]	New Haven[3]	State
PLW HIV	652	1,050	1,847
PLW AIDS	2,422	3,977	7,002
Total PLWHA	3,074	5,027	8,849
HIV women	220	395	663
HIV youth	52	70	137
HIV children	12	22	35
HIV infants	-	-	-
AIDS women	733	1,290	2,206
AIDS youth	20	71	100
AIDS children	60	14	22
AIDS infants	1	1	1

[1] TGA=Transitional Grant Area.

[2] Hartford TGA consists of Hartford, Tolland, and Middlesex Counties.

[3] New Haven TGA consists of New Haven and Fairfield Counties.

Figure 4.1: Ryan White Transitional Grant Areas, Connecticut, 2007.
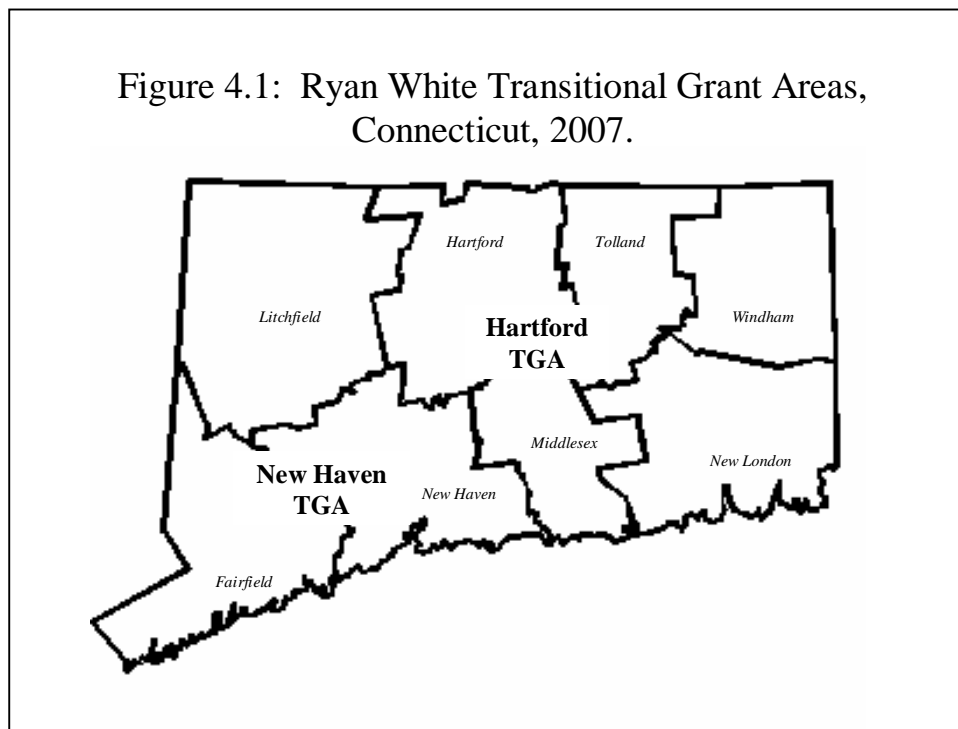
Figure 4.2: RYAN WHITE: Comparing the Percentage of PLWA by Demographic and HIV Infection Risk Groups, Hartford and New Haven TGAs, Connecticut, 2006.
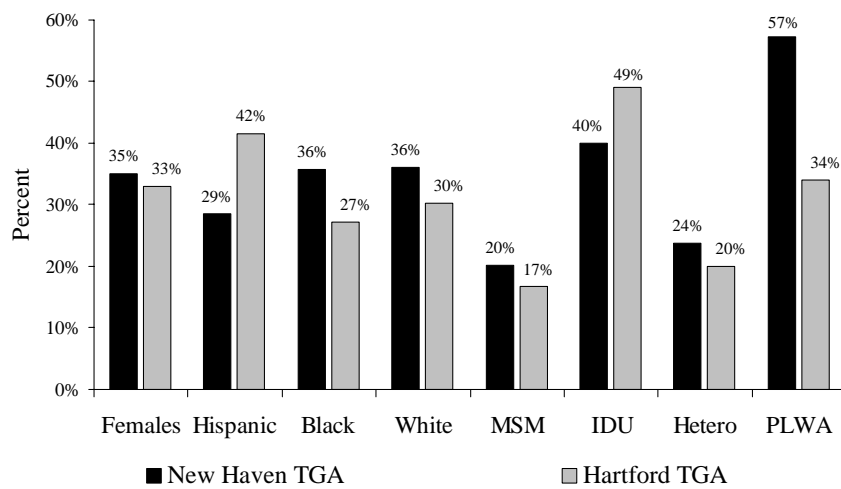
Table 4.2: PLWHA by Ryan White TGA, Risk, Race/Ethnicity, and Sex, Connecticut, 2006.

| | | Sex | | Race/ethnicity | | | | Risk/mode of transmission | | | | | |
	Total	Male %	Female %	White %	Black %	Hispanic %	Other %	MSM %	IDU %	MSM/IDU %	Hetero %	Oth/unk %	Pedi %
Hartford TGA	3,370	67.0	33.0	30.3	27.1	41.6	1.0	16.8	49.1	1.8	20.0	11.6	0.7
New Haven TGA	5,647	64.7	35.3	34.5	35.7	28.5	1.3	20.1	40.0	1.8	23.8	12.9	1.3
Other towns	854	67.9	32.1	56.1	18.5	22.7	2.7	26.2	39.6	2.1	20.3	10.9	0.9
Total	9,871	65.8	34.2	35.0	31.3	32.4	1.3	19.5	43.0	1.9	22.2	12.3	1.1

Table 4.3: RYAN WHTE: <u>Hartford TGA</u>: PLWHA by Race/Ethnicity, Sex, Current Age, and Risk Group, Connecticut, 2006.

	MSM		IDU		MSM/IDU		Hetero		Oth/unk		Pedi		Total	
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	566	16.8	1,653	49.1	62	1.8	675	20.0	392	11.6	22	0.7	3,370	100.0
Sex														
Male	566	25.1	1,153	51.1	62	2.7	213	9.4	253	11.2	10	0.4	2,257	67.0
Female	--	--	500	44.9	--	--	462	41.5	139	12.5	12	1.1	1,113	33.0
Race/ethnicity														
White	359	35.2	348	34.1	17	1.7	148	14.5	145	14.2	4	0.4	1,021	30.3
Black	97	10.6	485	53.1	17	1.9	220	24.1	90	9.8	5	0.5	914	27.1
Hispanic	105	7.5	810	57.8	28	2.0	300	21.4	146	10.4	13	0.9	1,402	41.6
Other	5	15.2	10	30.3	--	--	7	21.2	11	33.3	--	--	33	1.0
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	5	100.0	5	0.1
13-19	2	11.1	--	--	--	--	2	11.1	--	--	14	77.8	18	0.5
20-29	35	22.3	40	25.5	3	1.9	36	22.9	40	25.5	3	1.9	157	4.7
30-39	114	18.4	242	39.0	9	1.5	161	26.0	94	15.2	--	--	620	18.4
40-49	234	16.1	762	52.4	35	2.4	264	18.2	159	10.9	--	--	1,454	43.1
50+	181	16.2	609	54.6	15	1.3	212	19.0	99	8.9	--	--	1,116	33.1

Table 4.4: RYAN WHITE: <u>New Haven TGA</u>: PLWHA by Race/Ethnicity, Sex, Current Age, and Risk Group, Connecticut, 2006.

| | \multicolumn{12}{c}{Risk/mode of transmission} | | | | | | | | | | | Total | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | Pedi | | | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	1,136	20.1	2,257	40.0	104	1.8	1,343	23.8	731	12.9	76	1.3	5,647	100.0
Sex														
Male	1,136	31.1	1,479	40.5	104	2.8	447	12.2	449	12.3	41	1.1	3,656	64.7
Female	--	--	778	39.1	--	--	896	45.0	282	14.2	35	1.8	1,991	35.3
Race/ethnicity														
White	697	35.7	642	32.9	47	2.4	303	15.5	253	13.0	9	0.5	1,951	34.5
Black	199	9.9	918	45.6	32	1.6	600	29.8	225	11.2	40	2.0	2,014	35.7
Hispanic	225	14.0	675	42.0	23	1.4	423	26.3	236	14.7	25	1.6	1,607	28.5
Other	15	20.0	22	29.3	2	2.7	17	22.7	17	22.7	2	2.7	75	1.3
Current age														
0-12	--	--	--	--	--	--	--	--	--	--	12	100.0	12	0.2
13-19	2	3.8	--	--	--	--	1	1.9	2	3.8	48	90.6	53	0.9
20-29	86	31.5	47	17.2	2	0.7	63	23.1	59	21.6	16	5.9	273	4.8
30-39	192	19.0	335	33.1	15	1.5	294	29.0	177	17.5	--	--	1,013	17.9
40-49	490	20.6	981	41.3	56	2.4	574	24.1	276	11.6	--	--	2,377	42.1
50+	366	19.1	894	46.6	31	1.6	411	21.4	217	11.3	--	--	1,919	34.0

Section 5:   Behavioral Risk

5.1   Behavioral Risk Factor Surveillance System (BRFSS)

- The BRFSS is an ongoing telephone survey of the general population of adults conducted in all 50 states and coordinated by the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. Households are randomly selected and contacted by a contractor who conducts most interviews in the evenings and on weekends. Once an interviewer reaches a household, a random selection of adult household members is made to choose one person to participate in the survey.

- The questionnaire changes somewhat from year-to-year and state-to-state to meet changing needs and address state-specific priorities. The BRFSS originally collected data on health behaviors related to the leading causes of death, but has since been expanded to include issues related to health care access, utilization of preventive health services, and to address emerging issues such as cigar smoking or diet pill use. Each month survey data are sent to the CDC for editing and checking. At the end of each year data are compiled and adjusted to be representative of all adults in the state, and returned to states for analysis and use in planning and monitoring health programs. Additional information is available at the DPH website (http://www.dph.state.ct.us/PB/HISR/BRFSS.htm).

HIV testing

- *Have you ever been HIV tested?* Of 3,689 respondents in the 2005 survey aged 18-64 years, 37.4% (adjusted) indicated that they had been tested for HIV (Table 5.1.1).

  - <u>Sex</u>: Females were slightly more likely to have been tested than males (40.2% and 34.5%).

  - <u>Race/ethnicity</u>: Among race/ethnicity groups, blacks (63.3%) and Hispanics (50.4%) were much more likely to report being tested than whites (34.0%).

  - <u>Age group</u>: Approximately half of respondents in the 25-44 age group were tested. In the younger age group, 18-24, 33.3% had been tested. After age 44, the percentage tested decreased with 25.1% in the 45-54 age group and only 17.6% in the 55-64 age group.

  - <u>Education</u>: HIV testing increased slightly with education from 32.8% among those with less than high school to 39.8% of college graduates.

  - <u>Income</u>: There was no discernable trend by income.

  - <u>Trend in testing</u>: The percentage of respondents who reported testing has been higher: 47.1% in 2004 and averaging 46.1% during 2000-2003 (the question wording has varied slightly over the years).

  - <u>Testing in pregnant women</u>: Among women who were pregnant at the time of the survey (2003-2005 combined due to low numbers) (n=172), 89.0% reported having been tested.

- *When were you tested?* Overall, 13.6% indicated it was in 2005, the same year as the survey. Half (50.8%) said between one and five years ago (2001-04) and 35.6% indicated they were tested more than five years ago (Table 5.1.2).

- *Where were you tested?* Overall, 46.5% indicated they had their last HIV test at their doctor or HMO; 2.5% at a counseling and testing site; 37.4% at a hospital or clinic; 0.4% in jail or prison; 0.1% in a drug rehabilitation facility; and 13.1% at home or elsewhere.

High-risk situations

- Due to low numbers of respondents in the sample with high-risk situations, data from 2003-2005 were combined for this analysis. BRFSS defined high-risk situations as one or more of the following events occurring in the past year: IDU, treatment for STD, received money or drugs in exchange for sex, or had anal sex without a condom. Participants who answered "don't know" or "refused" were excluded from the analysis.

- Of the 16,601 statewide participants during 2003-2005, 86% were white, 6% black, and 6% Hispanic. Of these, 12,167 provided usable answers to the question about high-risk situations.

- Overall, 3.8% (adjusted) of participants (n=382) admitted having a high-risk situation in the previous year (Table 5.1.3). A number of characteristics were significantly ($p < 0.05$) associated with high-risk situations.

  - <u>Sex</u>: 4.5% of males, 3.1% of females.

  - <u>Race/ethnicity</u>: 6.9% of Hispanics, 5.0% of blacks, and 3.3 % of whites.

  - <u>Age group</u>: 5.2% of the 18-44 age group, 1.8% of the 45-64 age group.

  - <u>Education</u>: 7.6% of less than high school, 2.5% of college graduates.

  - <u>Income</u>: Respondents with a lower income (<$25,000) had higher levels of risk than higher income ($50,000+) (6.5% and 2.3%).

  - <u>Employment</u>: Respondents who were unemployed had higher levels of risk than employed respondents (6.7% and 3.7%).

  - <u>Mental health status</u>: The percentage of respondents with high-risk situations increased with the number of days where mental health status was reported to be 'not good.' Of respondents who indicated that their mental health was good 30 days per month, 2.7% had high-risk situations. This increased to 10.2% for respondents with 22-30 days where mental status was 'not good.'

  - <u>HIV testing</u>: Of respondents with high-risk behavior, 60.1% reported having been tested for HIV compared with 43.0% of those without high-risk behavior.

Table 5.1.1: BRFSS[1], Telephone
Survey of Adults Age 18-64,
Connecticut, 2005.

"Have you ever been tested for HIV?"

	% yes
Total	37.4
Sex	
Male	34.5
Female	40.2
Race/ethnicity	
White	34.0
Black	63.3
Hispanic	50.4
Age group	
18-24	33.3
25-34	56.4
35-44	51.4
45-54	25.1
55-64	17.6
Education	
Less Than HS	32.8
H.S. or GED	33.6
Some Post-HS	37.9
College Graduate	39.8
Income	
< $15,000	39.6
$15,000- 24,999	43.8
$25,000- 34,999	47.5
$35,000- 49,999	40.2
$50,000- 74,999	31.3
$75,000+	37.3

[1] Denominator excludes do not
know/refused/missing responses.

Table 5.1.2: BRFSS, Telephone Survey of Adults Aged 18-64, Connecticut, 2005.

"When were you tested for HIV?"

	Total	1990 and before		1991-1995		1996-2000		2001-2004		2005	
		N	%	N	%	N	%	N	%	N	%
Total	1,293	65	4.5	176	12.3	260	18.8	641	50.8	151	13.6
Sex											
Male	461	26	5.3	71	13.8	87	16.9	215	48.6	62	15.3
Female	832	39	3.9	105	11.0	173	20.4	426	52.6	89	12.1
Race/ethnicity											
White	902	52	5.0	147	14.6	194	20.6	423	48.9	86	10.8
Black	158	1	0.1	12	5.6	--	--	--	--	--	--
Hispanic	161	8	4.2	12	6.7	29	10.7	--	--	--	--
Age group											
18-24	70	--	--	--	--	1	2.2	--	--	--	--
25-34	330	4	1.3	14	4.5	53	19.2	206	59.5	53	15.5
35-44	469	21	5.5	79	18.4	109	23.0	222	45.3	38	7.8
45-54	278	26	11.2	53	19.4	65	20.6	111	39.2	23	9.6
55-64	140	13	7.2	29	20.0	31	22.7	53	34.9	14	15.2
Education											
Less Than H.S.	79	3	4.1	4	5.1	--	--	--	--	--	--
H.S. or G.E.D.	270	14	4.5	28	9.6	62	19.4	133	51.3	33	15.2
Some Post-H.S.	302	15	3.0	40	10.9	58	18.4	156	54.1	33	13.5
College Graduate	639	33	5.4	104	14.9	128	19.0	304	48.8	70	11.9
Income											
Less than $15,000	83	4	5.6	8	7.9	12	8.7	--	--	--	--
$15,000- 24,999	137	4	3.0	11	7.4	--	--	--	--	18	12.5
$25,000- 34,999	118	6	3.0	10	6.6	21	11.2	--	--	17	17.2
$35,000- 49,999	149	5	1.5	13	6.1	34	20.7	--	--	19	18.1
$50,000- 74,999	195	6	3.5	37	16.6	42	21.5	88	46.3	22	12.1
$75,000+	490	34	6.3	79	15.2	100	20.2	235	49.3	42	8.9

Table 5.1.3: BRFSS, telephone survey of adults aged 18-64, Connecticut, 2003-2005.

Percentage of respondents with high-risk situations[1].

Characteristic	%
Total	3.8
Sex	
Male	4.5
Female	3.1
Race/ethnicity	
White	3.3
Black	5.0
Hispanic	6.9
Age group	
18 – 44 years old	5.2
45 – 64 years old	1.8
Education	
< High school	7.6
High school	4.3
Some college	4.6
College graduate	2.5
Income	
< $25,000	6.5
$25,000 - $49,999	5.3
$50,000 +	2.3
Employment	
Unemployed	6.7
Employed	3.7
Mental health	
Good 30 days/month	2.7
Not good 1-7 days/month	3.9
Not good 8-21 days/month	7.7
Not good 21-30 days/month	10.2

[1] In the past year: IDU, treatment for STD, received money or drugs in exchange for sex, anal sex without a condom.

5.2 Connecticut School Health Survey (2005)

- A total of 2,256 students from 45 Connecticut high schools completed the self-administered survey in 2005. Participants were 51.2% male and 48.8% female; 69.8% white, 13.5% black, 13.9% Hispanic, and 2.7% other race; respondents were equally distributed among grades 9 to 12. There was a 60% response rate.

- Included in this report are selected findings from the survey. The full report can be found at: http://www.dph.state.ct.us/PB/HISR/CSHS.htm.

Sexual activity and condom use

- 35.6% of high school students had sexual intercourse at least once in the past three months (currently sexually active) (Table 5.2.1).

- The percentage of students who were currently sexually active increased approximately 2.6 times between grades 9 and 12 (20.8% and 55.1%); the increase was statistically significant. Current sexual activity among students increased dramatically between grades 10 and 11 (26.5% and 44.3%) (Figure 5.2.2).

- Of the high school students who were currently sexually active, 64.3% used a condom the last time they had sexual intercourse (Figure 5.2.4).

- The percentage of students who smoked cigarettes on one or more of the past 30 days (current cigarette smoking) increased significantly between grades 9 and 12 (12.3% and 23.4%). The percentage of students reporting various high-risk sexual behaviors was higher in smokers compared to non-smokers (Figure 5.2.5).

- About 9 in 10 students in grades 9-12 had been taught about HIV/AIDS infection. The percentage was highest among white students (91.2% - 96.1%), while among black and Hispanic students the percentage varied by grade and was somewhat lower (72.9% - 88.5%). About half (48.7%) of all students had a conversation once or more in the past year with their parents or other adults in the student's family about sexuality or ways to prevent HIV infection, other sexually transmitted diseases, or pregnancy.

- Overall, 72.1% had been taught how hepatitis A, B, and C viruses are spread.

Use of drugs and alcohol

- Overall, few students reported ever using heroin (4.3%), cocaine (7.8%), methamphetamines (5.9%), or ecstasy (6.4%). Higher percentages used marijuana (39.8%; 50.0% in 12th grade).

- Overall, 45.3% of students reported having at least one drink of alcohol on one or more days in the past 30 days. 27.3% reported using alcohol or other drugs before their last sexual intercourse. Among Connecticut high school students who were currently sexually active, white students were significantly more likely than Hispanic students to have used alcohol or other drugs the last time they had sexual intercourse (30.3% and 14.5%) (Figure 5.2.3).

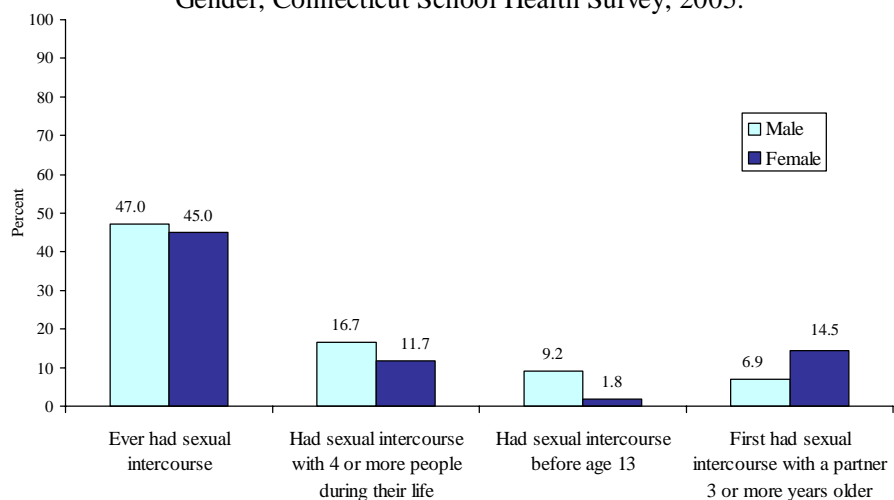Table 5.2.1: Percentage of Students Who Had Sexual Intercourse in the Past Three Months, Connecticut School Health Survey, 2005.[1, 2]

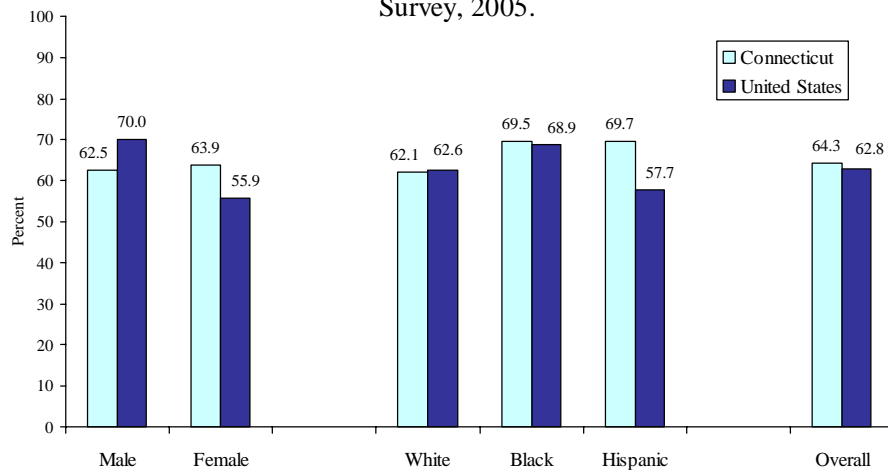|	Total		Males		Females	
	N	%	N	%	N	%
Total	2,005	35.6	999	35.9	994	35.2
Age						
15 or younger	735	20.6	345	22.1	389	19.2
16 or 17	1,008	40.2	496	38.0	508	42.1
18 or older	255	57.8	157	58.6	97	-[3]
Grade						
9	572	20.8	287	22.7	282	18.5
10	527	26.5	242	26.2	285	26.8
11	489	44.3	242	45.5	246	43.2
12	391	55.1	215	53.1	174	57.3
Race/ethnicity[4]						
Black	237	47.0	120	53.1	114	40.0
Hispanic	376	43.8	164	48.0	211	40.4
White	1,144	32.0	579	31.0	563	33.0

[1] There were 251 students who did not provide usable data for this question.
[2] N is the number of students (unweighted) responding to this question.
[3] Too few respondents for statistical analysis.
[4] Other and multiple race not included as categories but are included in total.

Table 5.2.2: Percentage of Students Who had Sexual Intercourse With Four or More People During Their Life, Connecticut School Health Survey, 2005.[1, 2]

	Total		Males		Females	
	N	%	N	%	N	%
Total	1,993	14.2	961	16.6	1,021	11.6
Age						
15 or younger	738	7.7	328	11.7	408	4.1
16 or 17	1,007	14.4	485	14.6	518	14.3
18 or older	243	29.7	147	33.4	95	-[3]
Grade						
9	563	8.2	271	11.5	288	5.0
10	520	8.8	228	10.6	292	7.1
11	494	16.7	240	20.2	254	13.5
12	394	23.8	210	24.6	182	22.8
Race/ethnicity[4]						
Black	227	26.2	110	38.2	115	14.7
Hispanic	369	18.5	153	25.4	216	13.3
White	1,156	11.2	569	11.3	586	10.9

[1] There were 263 students who did not provide usable data for this question.
[2] N is the number of students (un-weighted) responding to this question.
[3] Too few respondents for statistical analysis.
[4] Other and multiple race not included as categories but are included in total.

Figure 5.2.1: Sexual Behaviors Among High School Students that Contribute to Unintended Pregnancy and Disease by Gender, Connecticut School Health Survey, 2005.

Figure 5.2.2: Percentage of Students Who Have Had Sexual Intercourse During the Past Three Months, Connecticut School Health Survey, 2005.

*Weighted data

65
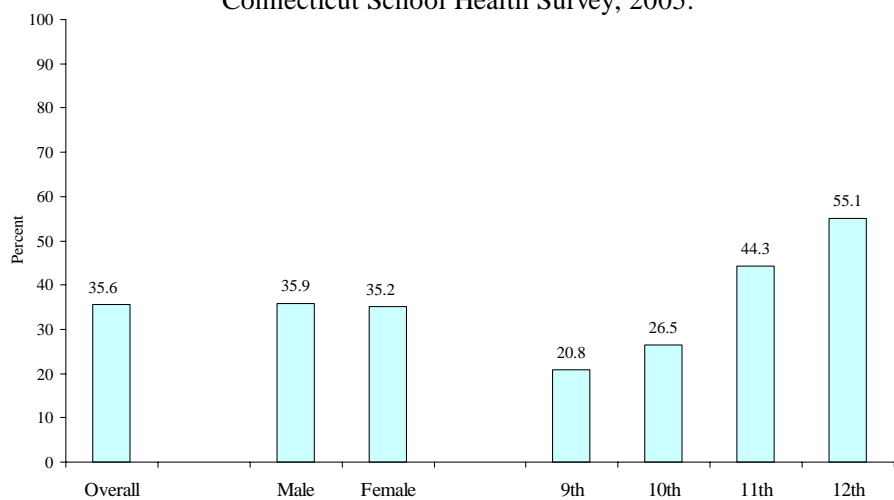
Figure 5.2.3: Connecticut and US High School Students Who Used Alcohol or Other Drugs Before Last Sexual Intercourse* by Gender and Race/Ethnicity, School Health Survey, 2005.
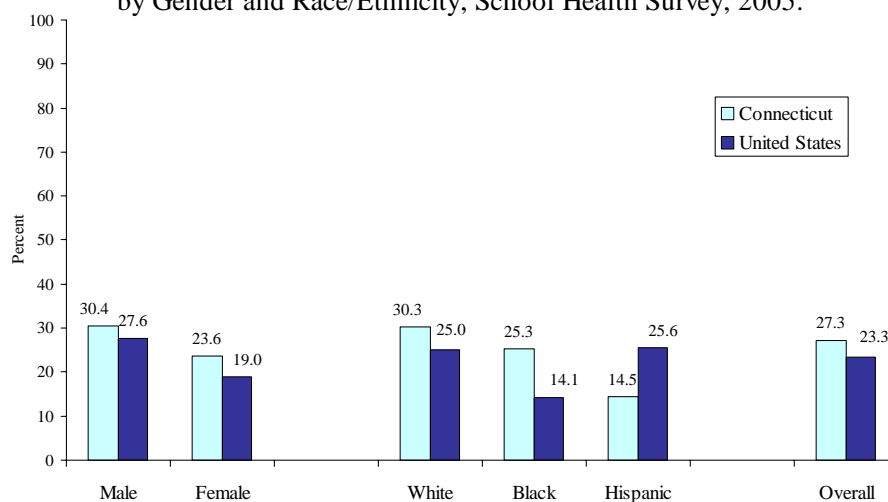
*Among the 35.6% of Connecticut and 33.9% of US high school students who are currently sexually active.

Figure 5.2.4: Percentage of Connecticut and US High School Students Who Used a Condom During Last Sexual Intercourse* by Gender and Race/Ethnicity, School Health Survey, 2005.

*Among the 35.6% of Connecticut and 33.9% of US high school students who are currently sexually active.

66

Figure 5.2.5: Sexual Behaviors Among High School Students by Smoking Status, Connecticut School Health Survey, 2005.
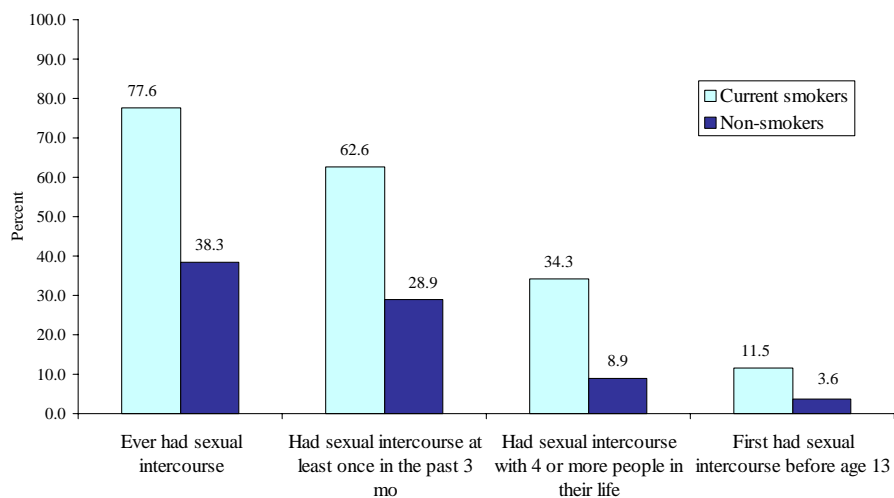
Figure 5.2.6: Percentage of Students Who Had Ever Been Taught in School About AIDS or HIV Infection, Connecticut School Health Survey, 2005.
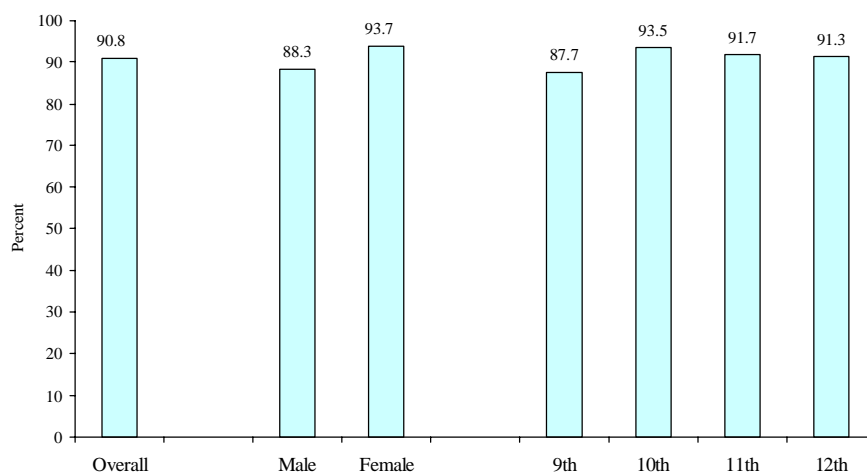
*Weighted data

5.3   National HIV Behavioral Surveillance

- In 2005, the HIV/AIDS Surveillance Program participated in a multi-state surveillance project to assess HIV risk behavior in injection drug users (IDU). The Connecticut project areas were the cities of Waterbury and Bridgeport. Respondent driven sampling was used to recruit 496 active IDUs for participation. Participants were interviewed about drug use, HIV testing, and sexual behaviors. The analysis provided here is preliminary and does not include adjustments for characteristics of the population. Additional analysis will be provided in other publications. In subsequent years the project will be conducted for MSM and high-risk heterosexuals and repeated in three-year cycles.

- Of the 496 participants, 71.2% were male, 28.2% were female, and 0.6% (n=3) were transgender; 20.6% were black, 52.4% were Hispanic, 20.8% were white, and 6.3% were other or missing race.

- When participants were asked if they used sterile needles in the past 12 months, 2.0% responded 'never', 6.9% 'rarely', 14.3% 'about half the time', 32.3% 'most of the time', and 44.6% 'always'. Participants were also asked about all sources of needles in the past year (Table 5.3.1). Participants could choose more than one source.

- Most participants reported having ever been HIV tested (94.8%). Of those tested, 96.0% knew their status (90.2% negative and 9.8% positive). Notably, two of the three transgender participants indicated they were HIV positive. The median time to the most recent test was 8.5 months.

- Among male participants, 90.3% had sex during the past 12 months. Of these, 40.3% had one sex partner and 59.8% had two or more. Among males with two or more sex partners, only 11.1% reported always using a condom. Among men with a 'main' sex partner, 54.0% did not use a condom during their last vaginal sex. Among men with 'casual' sex partners, 45.9% did not use a condom during their last vaginal sex.

- Among female participants, 84.3% had sex during the past 12 months. Among the sexually active, 47.5% had one sex partner during past year and 52.5% had two or more. Among women with a 'main' sex partner, 80.7% did not use a condom during their last vaginal sex.

Table 5.3.1: National HIV Behavioral Surveillance: IDU source of needles in the past 12 months[1], Connecticut, 2005.

Source of needles	Number of responses	Percentage choosing this source (n=496)
Friend	268	54.0%
Drug dealer/gallery	127	25.6%
Pharmacy	356	71.8%
MD or hospital	64	12.9%
Needle exchange program	202	40.7%
Total responses	1,017	

[1]Participants were able to choose more than one source of needles.

Section 6:   Sexually Transmitted Diseases Surveillance

- In this section Connecticut surveillance data for chlamydia, gonorrhea, and syphilis are provided. Surveillance for these diseases is conducted using reports from laboratories and providers similar to methods described for HIV and AIDS. Table 6.1 shows the distribution of chlamydia, gonorrhea and syphilis by county and Table 6.2 by towns with a combined total of 100 or more cases. Table 6.3 shows the distribution of STD cases by age group.

- *Advantages of STD data:* a) Unlike HIV infection, these diseases are often immediately symptomatic leading to prompt testing and diagnosis; b) It is recommended that all women <25 years of age receive annual screening for chlamydia and gonorrhea; c) STDs are a marker for recent high-risk sexual behavior; d) Interviews in the context of partner notification are conducted with all syphilis cases and have established MSM as an emerging risk factor.

- *Disadvantages of STD data:* a) Gonorrhea and chlamydia race/ethnicity information is incomplete in about one-third of reports; b) Few interviews are conducted with gonorrhea and chlamydia cases due to the high number of cases reported.

Table 6.1: Chlamydia, Gonorrhea, and Syphilis by County, Connecticut, 2006.

| | | Chlamydia | | Gonorrhea | | Syphilis | |
| | | | % of | | % of | | % of |
	Total	N	disease	N	disease	N	disease
TOTAL	13,628	10,952	100	2,612	100	64	100
UNKNOWN	931	792	7.2	139	5.3	--	--
HARTFORD	4,283	3,363	30.7	899	34.4	21	32.8
NEW HAVEN	4,081	3,215	29.4	845	32.4	21	32.8
FAIRFIELD	2,689	2,175	19.9	501	19.2	13	20.3
NEW LONDON	699	595	5.4	98	3.8	6	9.4
MIDDLESEX	264	201	1.8	62	2.4	1	1.6
WINDHAM	247	230	2.1	16	0.6	1	1.6
TOLLAND	219	196	1.8	22	0.8	1	1.6
LITCHFIELD	215	185	1.7	30	1.1	--	--

Table 6.2: Chlamydia, Gonorrhea, and Syphilis by Town, Connecticut, 2006.

	Total		Chlamydia	Gonorrhea	Syphilis
	N	%	N	N	N
TOTAL	13,628	100.0%	10,952	2,612	64
UNKNOWN	1,154	8.5%	979	175	0
ALL OTHER TOWNS	2,050	15.0%	1,764	273	13
HARTFORD	2,221	16.3%	1,671	540	10
NEW HAVEN	1,833	13.5%	1,409	418	6
BRIDGEPORT	1,455	10.7%	1,126	324	5
WATERBURY	906	6.6%	697	204	5
NEW BRITAIN	442	3.2%	385	57	0
EAST HARTFORD	344	2.5%	268	71	5
STAMFORD	300	2.2%	261	37	2
HAMDEN	262	1.9%	188	72	2
MANCHESTER	243	1.8%	197	46	0
WEST HAVEN	242	1.8%	206	35	1
NORWALK	237	1.7%	196	39	2
MERIDEN	229	1.7%	193	33	3
NORWICH	209	1.5%	172	37	0
NEW LONDON	181	1.3%	161	19	1
BLOOMFIELD	165	1.2%	136	29	0
MIDDLETOWN	161	1.2%	117	43	1
DANBURY	144	1.1%	122	21	1
BRISTOL	141	1.0%	119	22	0
WINDHAM	137	1.0%	128	8	1
WINDSOR	129	0.9%	91	35	3
GROTON	120	0.9%	101	16	3
STRATFORD	119	0.9%	104	15	0
WEST HARTFORD	103	0.8%	80	23	0
ANSONIA	101	0.7%	81	20	0

Table 6.3: Chlamydia, Gonorrhea, and Syphilis by Age Group, Connecticut, 2006.

	Total		Chlamydia		Gonorrhea		Syphilis	
	N	%	N	%	N	%	N	%
<10	20	0.1%	16	0.1%	4	0.2%	0	0.0%
10-14	200	1.5%	173	1.6%	27	1.0%	0	0.0%
15-19	4,225	31.0%	3,610	33.0%	612	23.4%	3	4.7%
20-24	4,731	34.7%	3,933	35.9%	785	30.1%	13	20.3%
25-29	2,202	16.2%	1,731	15.8%	464	17.8%	7	10.9%
30-34	962	7.1%	683	6.2%	271	10.4%	8	12.5%
35-39	577	4.2%	374	3.4%	192	7.4%	11	17.2%
40-44	304	2.2%	161	1.5%	134	5.1%	9	14.1%
45+	282	2.1%	156	1.4%	113	4.3%	13	20.3%
Unkn	125	0.9%	115	1.1%	10	0.4%	0	0.0%
Total	13,628	100.0%	10,952	100.0%	2,612	100.0%	64	100.0%

6.1   Gonorrhea

- The trend in reported gonorrhea cases for 2002-2006 is shown in Table 6.1.1 by sex and race.

- During 2002-2006, 2,612-3,370 cases were reported each year with a downward trend over that time.

- Overall, 40.7% were male and 59.3% female.

- In 2006, 10.1% were white, 49.4% were black and 12.0% were Hispanic (Table 6.1.1), Importantly, in 27.6% of cases race/ethnicity was unknown.

- In 2006, over half (54.7%) of reported cases were in people under 25 years of age, with 30.1% in the 20-24 age group (Table 6.3).

Table 6.1.1: Gonorrhea by Sex, Race/ethnicity, and Year of Report, Connecticut, 2002-2006.

		Sex		Race/ethnicity				
		Male	Female	White	Black	Hispanic	Other	Unkn
	Total	% of total	% of total	% of total	% of total	% of total	% of total	% of total
2002	3,370	41.1	58.9	14.3	41.6	11.5	0.5	32.0
2003	2,977	38.6	61.4	14.7	42.4	12.8	0.7	29.5
2004	2,861	38.7	61.3	11.7	43.4	11.4	0.6	32.8
2005	2,750	42.2	57.8	10.8	46.5	13.9	0.5	28.3
2006	2,612	43.4	56.6	10.1	49.4	12.0	0.9	27.6
Total	14,570	40.7	59.3	12.5	44.4	12.3	0.6	30.2

6.2   Chlamydia

- The trend in reported chlamydia cases for 2002-2006 is shown in Table 6.2.1 by sex and race.

- During 2002-2006, 9,042-11,037 cases of chlamydia were reported each year (Table 6.2.1). In 2006, with 10,952 reported, an average of 30 cases were reported every day.

- Overall, 76.9% of cases were female and 23.1% male.

- In 2006, 14.6% were white, 31.9% black, and 16.5% Hispanic (Table 6.2.1). Importantly, in 36.2% of cases race/ethnicity was unknown.

- In 2006, 70.6% of cases were less than 25 years of age, with 35.9% of cases in the 20-24 age group (Table 6.3).

Table 6.2.1: Chlamydia by Sex, Race/Ethnicity, and Year of Report, Connecticut, 2002-2006.

		Sex		Race/ethnicity				
		Male	Female	White	Black	Hispanic	Other	Unkn
	Total	% of total	% of total	% of total	% of total	% of total	% of total	% of total
2002	10,115	21.2	78.8	13.6	31.7	17.1	0.8	36.8
2003	9,042	22.1	77.9	15.0	31.5	17.8	0.9	34.8
2004	9,554	22.7	77.3	13.5	32.5	17.0	1.0	36.0
2005	11,037	24.0	76.0	14.8	32.1	17.4	0.9	34.9
2006	10,952	25.1	74.9	14.6	31.9	16.5	0.8	36.2
Total	50,700	23.1	76.9	14.3	32.0	17.1	0.9	35.8

6.3   Syphilis

- The number of primary and secondary (infectious) syphilis cases in Connecticut declined from 1990 when 1,139 cases were reported to 2001 when 12 cases were reported. Since 2001 there has been an emergence of syphilis both nationally and in Connecticut, primarily in gay men (Figure 6.3.1). In 2006, 64 cases were reported.

- During 2002-2006, 27-64 cases were reported (95.0% were male, 47.3% white, 32.4% black, and 15.8% Hispanic) (Table 6.3.1).

- Unlike chlamydia and gonorrhea, syphilis is not predominant in a particular age group with between 10% and 20% in each of the age groups above age 19 (Table 6.3). In 2006, 20.3% of cases were 45+ years of age.

- DPH STD Program staff attempt to interview all syphilis cases. Included in the interview are questions about risk behavior. The percentage of cases that were MSM increased from 1.2% in 1995 to 20% in 2000 (see *2003 HIV/AIDS Epidemiologic Profile*). Since 2000, the percentage of cases with MSM risk increased steadily to 85.9% in 2006. HIV testing is offered to all syphilis cases. During 2002-2006, 34.6% of syphilis cases have also been HIV positive (ranging from 20.0% to 49.9%).

- Figure 6.3.1 shows the trend from 1995 to 2006 in male syphilis cases and the number with MSM risk. This graph shows the transition in risk from non-MSM to MSM that occurred during 2000-2001. Since that time MSM has emerged as the predominant risk factor for syphilis and accounted for 85.9% of syphilis cases in 2006.

Figure 6.3.1: Number of MALE Syphilis Cases and with MSM Risk, Connecticut, 1995-2006.
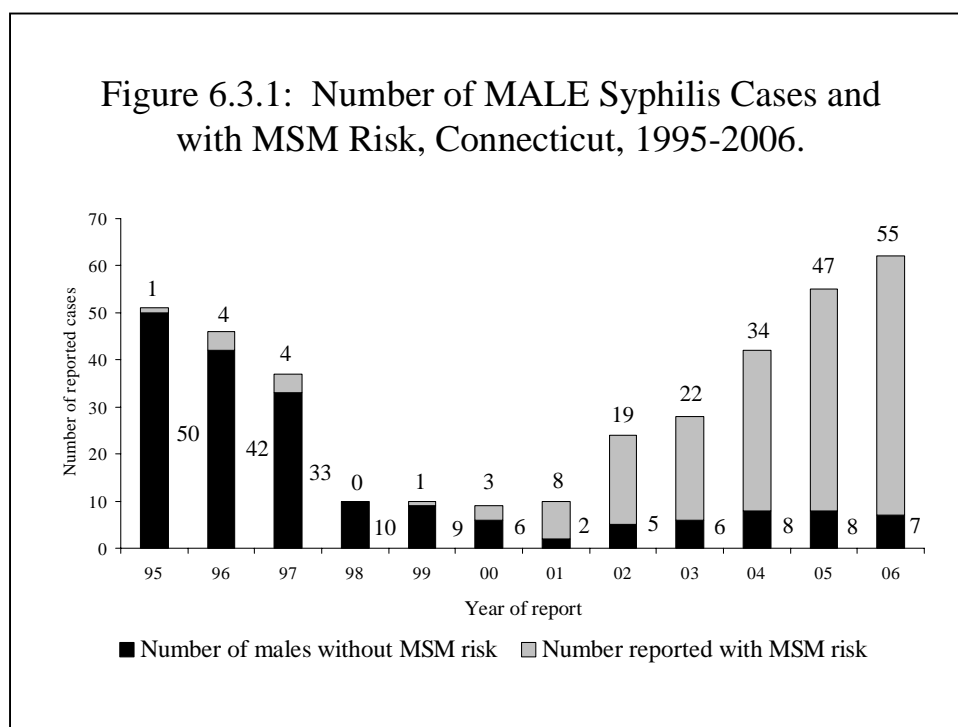
Table 6.3.1: Primary and Secondary Syphilis by Year of Report, Sex, Race/Ethnicity, Risk, Connecticut, 2002-2006.

| | | Sex | | Race/ethnicity | | | | | Risk[1] | | | |
| | | Male | Female | White | Black | Hispanic | Other | Unkn | MSM | IDU | Other | HIV+[2] |
	Total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total
2002	27	88.9	11.1	56.6	29.6	11.1	3.7		70.4	0.0	29.6	49.9
2003	29	96.6	3.4	65.5	17.2	17.2	--	--	76.7	2.0	16.0	30.0
2004	45	93.3	6.7	46.7	26.7	22.2	2.2	2.2	75.5	2.0	31.9	20.0
2005	57	96.5	3.5	40.4	42.1	14.0	3.5	--	82.8	1.0	27.0	36.0
2006	64	96.9	3.1	42.2	35.9	14.1	3.1	4.7	85.9	3.0	15.0	39.1
Total	222	95.0	5.0	47.3	32.4	15.8	2.7	1.8	79.9	1.8	23.4	34.6

[1] Cases can have more than one risk.

[2] HIV testing is recommended for all syphilis cases as part of DPH follow-up.

Section 7:   Hepatitis C

- Hepatitis C surveillance information is included in the HIV/AIDS Epi Profile because it has modes of transmission in common with HIV. Consequently many people with HIV infection are co-infected with hepatitis C (HCV). Injection drug use is a major contributor to the transmission of both HCV and HIV in Connecticut.

- Hepatitis A and B: In the past several years, hepatitis A has been associated with outbreaks in MSM in Connecticut and nationally (see *2003 HIV/AIDS Epidemiologic Profile*). Hepatitis B can also be transmitted sexually and through blood. Surveillance information about hepatitis A and B can be found at the DPH web site (www.dph.state.ct.us).

7.1   Hepatitis C Surveillance Methods in Connecticut

- The Connecticut Department of Public Health (DPH) conducts public health surveillance for many infectious diseases including HCV.

- Reportable diseases are reported to DPH and local health departments (HIV/AIDS is not reported to local health departments) by the diagnosing physician and the laboratory that performs tests specific for the disease.

- The reportable laboratory test for hepatitis C is anti-HCV. A person who is positive for anti-HCV may be acutely or chronically infected or may have been infected in the past and is no longer infected (resolved). They may also be false positive. Additional laboratory tests are recommended to confirm the anti-HCV result. Results of confirmatory tests were made reportable to DPH in 2004.

- In 2004, DPH implemented enhanced follow-up with HCV providers of cases reported in New Haven County to obtain additional information including: symptoms, other laboratory test results, reason for testing, and information about potential sources of infection. Enhanced follow-up has been extended to Hartford and Fairfield Counties in 2007.

- DPH periodically matches the HIV/AIDS and HCV registries to identify and characterize individuals infected with both viruses. Information from the most recent match is provided below.

7.2   Hepatitis C in Connecticut and the US

- It is estimated that 3.9 million US residents (1.8%) have been infected with HCV and that 2.9 million are chronically infected. In the US, the rate of infection is highest among blacks (3.2%) and lowest among whites (1.5%). Applying 1.8% to Connecticut would mean that approximately 60,000 residents of Connecticut have been exposed to HCV.

- CDC estimates that 20,000 acute HCV cases occurred in the U.S. in 2005 (www.cdc.gov). Unlike hepatitis A and B, there is no laboratory test for acute HCV infection. Only physicians can diagnose acute HCV infections. As a result very few acute HCV cases have been reported. Many newly infected people have no symptoms and the chronic state can be asymptomatic for decades making accurate estimates of incidence difficult.

- HCV infection becomes chronic in a high proportion of acutely infected individuals, 70-80%. However, because the majority of cases cannot be confirmed to be chronic

infections, surveillance is conducted for 'chronic/resolved' HCV cases. These cases are defined by confirmed antibody positive test results.

- Incidence, as shown in Figure 7.2.1, has fallen to very low levels nationally, primarily in persons aged 25-39 years and in IDU due most likely to risk reduction in that group. In spite of the declines in incidence, the predominant risk group is still IDU (60%) with sexual contact accounting for 15% (Figure 7.2.2). While there is an association of HCV transmission with high-risk sexual behavior, various studies have shown that it is inefficiently transmitted through this route.

- During 2004-2006, 11,903 HCV reports were reported to DPH with confirmation reports received for 57.5% (n=6,843).

- Table 7.2.1 shows the distribution of confirmed chronic/resolved cases reported during 2004-06 by county. Similar to HIV/AIDS, the majority (61.2%) of reports come from the three most populous and urbanized counties, Hartford, Fairfield, and New Haven.

- Table 7.2.3 shows the distribution and trend in towns with more than a total of 50 cases.

- Among the confirmed chronic/resolved cases reported in New Haven County (2005-06) and for which enhanced follow-up was conducted (Table 7.2.4), 35.4% were female and 64.6% male. Race/ethnicity was reported in 66.7% of cases with 41.1% white, 12.3% black, and 11.7% Hispanic. Cases tended to be in middle age and higher with 32.8% 40-49 and 42.7% 50 years of age or older.

- Risk factors for potential source of infection were reported in only 31.0% of cases. Risk factor can be difficult to assess due to the usual inability to determine when the infection occurred. For the 430 cases where risk was determined, 77.4% had a history of IDU, 5.8% had sexual contact with an HCV infected person, 0.7% had household contact with an HCV infected person, 11.6% reported no other risk factor than a blood transfusion (before screening) (CDC recommends HCV testing for anyone receiving a blood transfusion prior to July 1992), and 4.4% reported no other risk factor than work in a medical or dental field. This profile of risk factors is consistent with national data. People with a history of IDU predominated in every age group but tended to be younger with 64.6% of IDU in the 20-49 age group.

- The reasons for testing reported by providers varied, with 48.3% not reporting a reason (Table 7.2.2). For cases where the answer was known, screening (automatic testing upon entry into a program such as drug rehab) was most frequent (37.4%) followed by elevated liver functions (23.7%), having risk factors for infection (19.1%), and other reasons (16.2%).

Figure 7.2.1: Estimated Incidence of Acute HCV Infection, United States, 1960-1999.
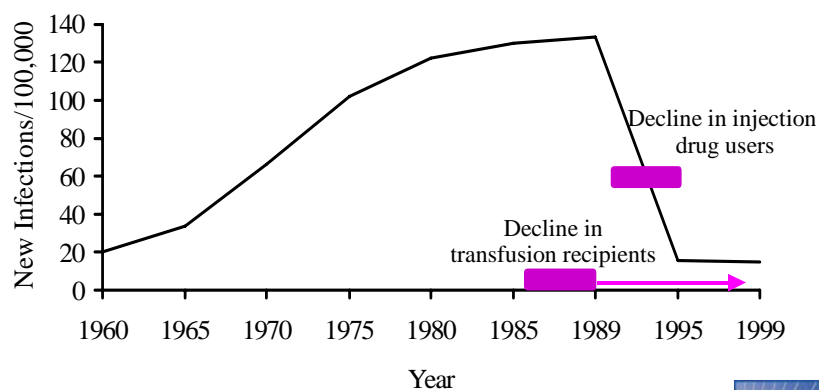
Source: Hepatology 2000;31:777-82; Hepatology 1997;26:62S-65S

Figure 7.2.2: Sources of Infection for Persons with Hepatitis C.

Injecting drug use 60%

Sexual 15%

Transfusion 10% (before screening)

Other* 5%

Unknown 10%
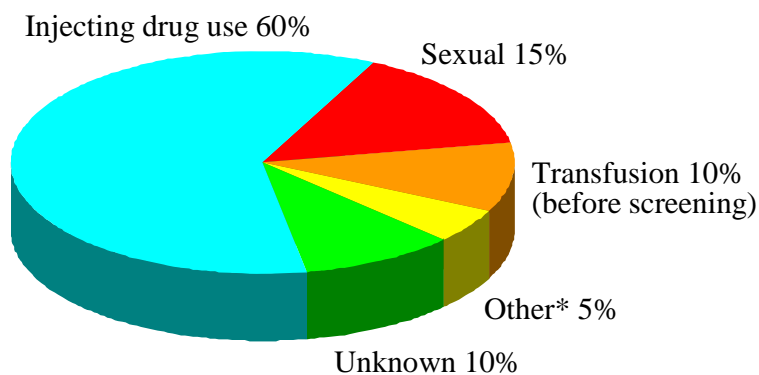
*Nosocomial; Health-care work; Perinatal

Source: Centers for Disease Control and Prevention

Table 7.2.1: Reports of Confirmed Chronic/Resolved Hepatitis C by County of Residence, Connecticut, 2004-2007.

	Year of report			Total	
	2004	2005	2006		
	N	N	N	N	%
TOTAL	1,640	2,644	2,559	6,843	100.0%
FACILITIES/DOC	193	209	232	634	9.3%
UNKNOWN	180	241	129	550	8.0%
NEW HAVEN	359	697	689	1,745	25.5%
FAIRFIELD	253	495	505	1,253	18.3%
HARTFORD	313	445	434	1,192	17.4%
NEW LONDON	137	213	192	542	7.9%
WINDHAM	76	108	120	304	4.4%
LITCHFIELD	48	105	139	292	4.3%
MIDDLESEX	48	81	59	188	2.7%
TOLLAND	33	50	60	143	2.1%

Table 7.2.2: Reason[1] for Testing Among Confirmed Chronic/Resolved Hepatitis C Cases, New Haven County, 2005-06.

Reason	N	%
Screening	268	19.3%
Elevated LFT[2]	170	12.3%
Risk factor	137	9.9%
Symptoms	7	0.5%
Patient request	18	1.3%
Other	116	8.4%
Unknown	670	48.3%
Total	1,386	100.0%

[1] Reason for testing was reported by the provider.

[2] Liver function tests.

Table 7.2.3: Reports of Confirmed Chronic/Resolved Hepatitis C by
Town of Residence, Connecticut, 2004-2006.

	Year of report			Total	
	2004	2005	2006		
	N	N	N	N	%
TOTAL	1640	2644	2559	6,843	100.0%
UNKNOWN	180	241	129	550	8.0%
FACILITIES/DOC	193	209	232	634	9.3%
ALL OTHER TOWNS	370	759	718	1,847	27.0%
NEW HAVEN	93	184	185	462	6.8%
BRIDGEPORT	94	182	181	457	6.7%
HARTFORD	126	136	112	374	5.5%
WATERBURY	75	112	112	299	4.4%
STAMFORD	42	56	54	152	2.2%
NORWALK	23	47	62	132	1.9%
NEW BRITAIN	39	41	48	128	1.9%
WEST HAVEN	22	58	45	125	1.8%
NORWICH	24	44	46	114	1.7%
EAST HAVEN	20	45	46	111	1.6%
MERIDEN	24	41	44	109	1.6%
BRISTOL	27	44	34	105	1.5%
NEW LONDON	34	32	38	104	1.5%
DANBURY	18	36	37	91	1.3%
KILLINGLY	26	28	34	88	1.3%
TORRINGTON	19	28	41	88	1.3%
HAMDEN	12	33	41	86	1.3%
EAST HARTFORD	21	29	34	84	1.2%
GROTON	24	28	28	80	1.2%
MILFORD	18	22	39	79	1.2%
MANCHESTER	18	20	33	71	1.0%
STRATFORD	21	22	27	70	1.0%
WINDHAM	12	26	32	70	1.0%
NAUGATUCK	14	19	31	64	0.9%
MIDDLETOWN	19	25	15	59	0.9%
BRANFORD	9	33	14	56	0.8%
ENFIELD	8	26	19	53	0.8%
GREENWICH	7	16	28	51	0.7%
WALLINGFORD	8	22	20	50	0.7%

Table 7.2.4: Confirmed Chronic/Resolved Hepatitis C Cases by Sex, Race/Ethnicity, Age, and Risk, New Haven County, 2005-06.

								Risk										
		IDU		Sex contact		Household contact		Transfusion		Medical/dental		None determined		Other/ unknown		Total	
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of Total
Total	333	24.0	25	1.8	3	0.2	50	3.6	19	1.4	71	5.1	885	63.9	1,386	100.0
Sex																
Female	103	21.0	11	2.2	1	0.2	27	5.5	9	1.8	37	7.6	302	61.6	490	35.4
Male	230	25.7	14	1.6	2	0.2	23	2.6	10	1.1	34	3.8	583	65.1	896	64.6
Race																
White	179	31.5	12	2.1	3	0.5	31	5.4	10	1.8	48	8.4	286	50.3	569	41.1
Black	46	26.9	3	1.8	--	--	7	4.1	4	2.3	8	4.7	103	60.2	171	12.3
Asian/PI	1	10.0	--	--	--	--	1	10.0	1	10.0	--	--	7	70.0	10	0.7
Hispanic	69	42.6	5	3.1	--	--	2	1.2	1	0.6	10	6.2	75	46.3	162	11.7
Other	--	--	--	--	--	--	2	16.7	--	--	2	16.7	8	66.7	12	0.9
Unknown	38	8.2	5	1.1	--	--	7	1.5	3	0.6	3	0.6	406	87.9	462	33.3
Age group																
0-19	6	31.6	--	--	--	--	1	5.3	--	--	2	10.5	10	52.6	19	1.4
20-29	51	36.4	2	1.4	1	0.7	5	3.6	--	--	3	2.1	78	55.7	140	10.1
30-39	59	32.8	5	2.8	--	--	2	1.1	4	2.2	5	2.8	105	58.3	180	13.0
40-49	105	23.1	6	1.3	1	0.2	10	2.2	6	1.3	21	4.6	306	67.3	455	32.8
50+	112	18.9	12	2.0	1	0.2	32	5.4	9	1.5	40	6.8	386	65.2	592	42.7

7.3   Matching PLWHA with the Hepatitis C Registry:

- The registry of people living with HIV or AIDS (PLWHA) was matched to the HCV registry (2006 yearend data). Of 9,871 reported PLWHA, 2,591 (26.2%) were also HCV positive. Of 43,376 HCV cases, 6.0% were PLWHA (the HCV registry does not include information about vital status).

Figure 7.3.1: Distribution of HCV-Positive PLWHA by HIV Risk Category, Connecticut, 2006.

79.7% of PLWHA who are HCV+ have a history of IDU

- Of 2,591 co-infected cases, 69.9% were male, 30.5% white, 32.0% black, 36.4% Hispanic, and 86.6% were 40 or older (Table 7.3.2). Not surprisingly, 79.7% were IDU, with small percentages of MSM (4.6%) and heterosexual (7.3%) (Figure 7.3.1).

- Of 4,248 PLWHA who have a history of IDU, 2,064 (48.6%) have also been reported with HCV (Table 7.3.1). There was a higher level in males compared to females (51.3% and 43.2%). There was a higher level in whites (52.8%) compared with blacks (45.3%), and Hispanics (48.4%). The prevalence of hepatitis C in the 30-39 group was twice as high as IDU in the 20-29 group (39.4% and 17.9%). Fifty percent of IDU-PLWA in the age 40+ groups, which includes 83.1% of IDU-PLWHA, were HCV positive.
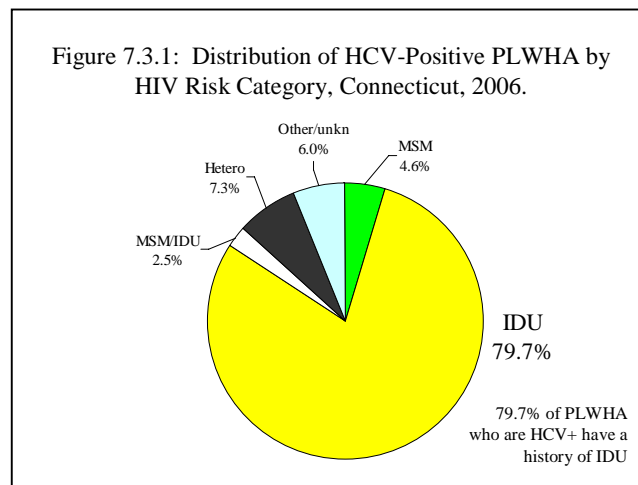
Table 7.3.1: Prevalence of Hepatitis C in PLWHA Who Have a History of IDU, Connecticut, 2006.

	IDU-PLWHA	HCV+	
	N	N	%
Total	4,248	2,064	48.6%
Sex			
Male	2,846	1,459	51.3%
Female	1,402	605	43.2%
Race			
White	1,144	604	52.8%
Black	1,477	669	45.3%
Hispanic	1,588	768	48.4%
Other	39	23	59.0%
Current age			
0-12	--	--	--
13-19	--	--	--
20-29	95	17	17.9%
30-39	625	246	39.4%
40-49	1,891	981	51.9%
50+	1,637	820	50.1%

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Table 7.3.2: Hepatitis C Positive PLWHA by Sex, Race/Ethnicity, Age, and HIV Risk, Connecticut, 2006.

| | HIV risk/mode of transmission | | | | | | | | | | Total | |
| | MSM | | IDU | | MSM/IDU | | Hetero | | Oth/unk | | | |
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	118	4.6	2,064	79.7	65	2.5	188	7.3	156	6.0	2,591	100.0
Sex												
Male	118	6.5	1,459	80.5	65	3.6	69	3.8	101	5.6	1,812	69.9
Female	--	--	605	77.7	--	--	119	15.3	55	7.1	779	30.1
Race/ethnicity												
White	55	7.0	604	76.4	21	2.7	46	5.8	65	8.2	791	30.5
Black	33	4.0	669	80.8	18	2.2	74	8.9	34	4.1	828	32.0
Hispanic	30	3.2	768	81.4	26	2.8	65	6.9	54	5.7	943	36.4
Other	--	--	23	79.3	--	--	3	10.3	3	10.3	29	1.1
Current age												
20-29	3	12.0	17	68.0	--	--	1	4.0	4	16.0	25	1.0
30-39	14	4.3	246	76.4	13	4.0	25	7.8	24	7.5	322	12.4
40-49	60	4.9	981	79.4	32	2.6	92	7.4	70	5.7	1,235	47.7
50+	41	4.1	820	81.3	20	2.0	70	6.9	58	5.7	1,009	38.9

Appendix 1.

HIV/AIDS Surveillance Methods

- *Uses of surveillance information*: The primary goal of the Connecticut Department of Public Health HIV/AIDS Surveillance Program is to systematically collect, analyze, interpret, and disseminate information about trends in HIV/AIDS in Connecticut. This information is used by a variety of state and federal agencies to develop policies and allocate funding for local prevention and care needs. Surveillance data are also used by media outlets such as television and newspapers to describe HIV/AIDS in Connecticut. Local health departments, non-governmental organizations and agencies, hospitals, physicians, students, and others also use HIV/AIDS surveillance data. Other important functions of the surveillance system at the state and national level include identification of clusters, unusual cases of transmission, emerging genetic variants, and drug-resistant strains.

- *Reportable diseases:* Connecticut law requires the Department of Public Health to maintain lists of reportable diseases and of related reportable laboratory findings. The lists include approximately 60 diseases and conditions of public health importance. Information is collected about each person with a disease or condition on the list. To be reported, a person with the disease or condition must meet the surveillance "case definition" for that disease. Cases are reported by the physician who diagnoses the disease and/or the laboratory that performs the test specific for the disease.

- *Surveillance of HIV/AIDS:* AIDS has been on the list of reportable diseases since the early 1980s. HIV infection in persons who do not meet the AIDS case definition was added to the reportable disease list in 2002. HIV viral load test results were made reportable in 2006. HIV is reported when an individual is confirmed HIV positive by Western Blot or other confirmatory test, including viral load. The AIDS case definition consists of either HIV positive with a low CD4-positive cell count (below 200 cells/microliter or less than 14% of total lymphocytes), or HIV positive and a diagnosis with one of several opportunistic infections or conditions (for example, *Pneumocystis carinii* pneumonia or cervical carcinoma). DPH maintains a computerized registry of HIV/AIDS cases. Persons testing anonymously at one of Connecticut's HIV counseling and testing sites are not reported.

- *Information collected about HIV and AIDS cases:* Various demographic and medical information is collected about each HIV/AIDS case including: laboratory test dates, sex, race, town of residence, exposure category, AIDS indicator diseases, treatment status, pregnancy status, and provider information. Additional information about some of these data elements is below.

- *Year of report:* The year of report is based on the date that the case was first reported to the Department of Public Health. HIV/AIDS cases may have been diagnosed in years prior to the year in which they were reported. Reporting delay results in an undercount of recently diagnosed cases.

- *Sex:* For each case of HIV/AIDS, information is collected about the person's sex. Male and female are the only options.

- *Race/ethnicity:* For each case of HIV/AIDS, information is collected about the person's race and ethnicity. Race categories include: White, Black, Asian, Native Hawaiian or other Pacific Islander, American Indian/Alaska Native, and Unknown. Ethnicity is coded as Hispanic, Not Hispanic, and Unknown. Also, cases can be of more than one race.

- *City of residence:* The city of residence in HIV/AIDS tables refers to the city where the case resided at the time of their initial diagnosis. Changes in residence are not systematically monitored.

- *Exposure categories:* For each case of HIV/AIDS, information is collected about the most likely way in which the person acquired their HIV infection. This information may not always be available, especially for recently reported cases. The provider may not have reported the information, or the patient may not have volunteered the information, may not be in care, or may have died. When the exposure category is unknown, HIV/AIDS tables and graphs classify these cases in a separate category, "Oth/unk." Over time, after additional follow-up with providers, many of these cases will be reclassified into one of the exposure categories.

  In the HIV/AIDS surveillance system, HIV/AIDS cases are only counted once in a hierarchy of exposure categories. Persons with more than one category are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They are in a separate category.

  - *Men who have sex with men (MSM)* – Men who report having sexual contact with men (homosexual contact) and men who report sexual contact with both men and women (bisexual contact).

  - *Injection drug use (IDU) –* Persons who have injected non-prescription drugs.

  - *Heterosexual contact –* Persons who have had heterosexual contact with a person with HIV infection or who is at high risk of HIV infection (IDU, bisexual male).

  - *Other –* Other exposure categories include received clotting factor or hemophilia/coagulation disorder, transfusion recipient, transplant recipient, and worker in a health care or clinical laboratory setting. Due to low numbers, these cases are classified together as "Oth/unk" in HIV/AIDS tables and graphs.

- *Opportunistic infections:* There are 26 opportunistic infections or conditions (not all are infections) that, together with HIV infection, indicate development of AIDS. These are also referred to as "AIDS indicator diseases." Many of these diseases result from impaired immunity. Having one of these diseases does not necessarily indicate that the person has HIV infection. The HIV/AIDS surveillance system collects information on the disease(s) that are reported with the initial diagnosis of AIDS. Indicator diseases that are subsequently diagnosed are not systematically monitored.

- ***HIV and AIDS in children:*** Information specific for pediatric cases of HIV/AIDS (<13 years of age) are also collected. A pediatric case report form is used to collect this information. In addition to routine surveillance, DPH has been conducting an enhanced surveillance project for perinatal exposure to HIV since 1999. For each case of perinatal HIV exposure, an extensive medical record extraction is conducted for the mother-child pair. Information collected about the mother includes demographics, risk behavior, HIV testing information, compliance with prenatal care, and types and duration of HIV treatment during pregnancy and labor/delivery. Information collected about the infant includes HIV preventive treatment, testing information, final HIV status, and birth defects.

- ***Incidence:*** Incidence rate is defined as the number of new cases in a defined population within a specified time period. To calculate incidence, the number of new cases of the disease and the size of the population at risk are needed. In the following example, the 2002 incidence of AIDS is calculated for Stamford and New London. Note, that in this example, the smaller city with a fewer number of cases has a higher incidence rate.

    - Stamford:
      [26 (AIDS cases) divided by 117,083 (population)] multiplied by 100,000 equals 22 per 100,000

    - New London:
      [12 (AIDS cases) divided by 25,671 (population)] multiplied by 100,000 equals 46 per 100,000

    - Incidence rates can be calculated for any group for which both the number of new cases and the size of the population are known. For example, rates can be calculated for gender, race, and age subgroups. Generally, population data is taken from the U.S. Census, conducted every ten years, most recently in 2000 (see www.census.gov).

    - Incidence rates cannot be calculated for some subgroups (i.e., IDU, MSM) because the size of these populations is unknown. Rates in populations of small size, such as small towns, can be misleading because the presence of a single case or a few cases within a small population can make a rate appear large.

- ***Prevalence:*** Prevalence is the number of existing cases of a disease in a defined population at a point in time. The prevalence of people living with AIDS (PLWA) for Stamford and New London on December 31, 2002 is shown below.

    - Stamford:
      [356 (PLWA) divided by 117,083 (population)] multiplied by 100,000 equals 304 per 100,000

    - New London:
      [138 (PLWA) divided by 25,671 (population)] multiplied by 100,000 equals 537 per 100,000

Appendix 2.

Description of Data Sources

Data source	Description of methods	Strengths and limitations
HIV/AIDS Surveillance Registry	Certain conditions of public health importance are required to be reported to the Department of Public Health. DPH staff follow up on reports to obtain information necessary to control transmission. Additional information about HIV/AIDS, Hepatitis C, and STD surveillance data can be linked from the following website: http://www.dph.state.ct.us (click on 'Publications and Statistics').	Strengths: • Statewide data. • Includes information about demographics and risk factors for infection. Weaknesses: • Information about recent cases tends to be incomplete. • HIV reporting was only recently implemented.
Hepatitis C Surveillance Registry	Laboratory findings for hepatitis C are laboratory reportable. Acute hepatitis C cases are physician reportable. Additional information about hepatitis C can be found at the following web site: http://www.dph.state.ct.us/BCH/infectiousdise/Hepatitis/hepatitis_home_page.htm	Strengths • Statewide data • Enhanced surveillance activities in New Haven and Hartford County. Weaknesses • Information about residence and demographics is incomplete. • Difficult to detect new infections.
Sexually Transmitted Diseases Surveillance Registry	Laboratory findings for chlamydia, gonorrhea, and syphilis are required to be reported to DPH. DPH staff follow-up on all syphilis cases to collect additional information about contacts, demographics, and behavioral characteristics. Additional information about STDs can be found at the following web site: http://www.dph.state.ct.us/BCH/infectiousdise/sexually.htm	Strengths: • Statewide data • Includes information about demographics and risk factors for infection. • Unlike HIV infection, these diseases are often immediately symptomatic leading to prompt diagnosis and testing. In addition, it is recommended that all women <25 years of age receive annual screening for chlamydia and gonorrhea; b) STDs are a marker for recent high-risk sexual behavior; c) Interviews in the context of partner notification are conducted with all syphilis cases and have established MSM as a risk factor. Weaknesses: • Information about recent cases may be incomplete.

Vital Records	Death data - Vital records supplied data about deaths in Connecticut. Included is information about primary and secondary causes of death. Information about deaths is provided through the Death Certificate reporting process. Death data for Connecticut can be found at the following website: http://www.dph.state.ct.us/PB/HISR/Deaths.htm	Strengths: • Statewide data • Includes information about persons with HIV who die. Weaknesses: • This data can be several years out of date due to time needed to complete reporting.
Vital Records	Hospitalization data - Hospitalization refers to any discharge from a non-federal, short-stay, acute-care, general hospital in Connecticut. Hospitalizations are expressed as numbers of discharges, not as unduplicated patients; a single patient with multiple hospitalizations can thus be counted more than once. Hospital discharges are recorded in the state's hospital discharge abstract and billing database, which is maintained by the Connecticut Office of Health Care Access. Hospitalization data can be found at the following website: http://www.dph.state.ct.us/OPPE/ANNUALREGREPORTS.HTM	Strengths: • Statewide data • Includes information about demographics of persons with HIV who are hospitalized. Weaknesses: • This data can be several years out of date due to time needed to complete reporting. • Only the first discharge code is included in the data presented here. • Discharge data is not de-duplicated (same patient could be in more than one discharge).
Behavioral Risk Factor Surveillance System (BRFSS)	The BRFSS is an ongoing telephone survey of adults conducted in all 50 states and coordinated by the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. Households are randomly selected and contacted by a contractor who conducts most interviews in the evenings and on weekends. Once an interviewer reaches a household, a random selection of adult household members is made to choose one person to participate in the survey. Listed and unlisted residential telephone numbers are included in the sample, but not business, Fax, modem or cell phone lines. The questionnaire changes somewhat from year-to-year and state-to-state to meet changing needs and address state specific priorities. The BRFSS originally collected data on health behaviors related to the leading causes of death, but has since been expanded to include issues related to health care access, utilization of preventive health services, and to address emerging issues such as cigar smoking or diet pill use. At the end of each year data are compiled and adjusted to be representative of all adults in the state, and returned to states for analysis. Data for all states are available via the CDC BRFSS website. Information about the BRFSS in Connecticut can be found at the following website: http://www.dph.state.ct.us/PB/HISR/BRFSS.htm	Strengths: • Statewide data • Includes information about demographics and risk factors for HIV. • Includes information about HIV testing. • Data are weighted to population characteristics. Weaknesses: • Telephone survey. • Difficult to reach populations and groups which represent small percentages of the population will be contacted infrequently.

Connecticut School Health Survey, 2005:	Based on the questionnaire utilized by the National Youth Risk Behavior Survey administered by the CDC. Includes questions about demographics, injury, violence, tobacco use, and alcohol and other drug use, sexual behaviors, dietary behaviors, and physical inactivity. A total of 60 high schools were selected using a two-stage cluster design to randomly select eligible schools. Questionnaires were administered anonymously and voluntarily. A total of 2,256 students from 45 high schools completed the self-administered survey. The school response rate was 76.3% and the student response rate was 78.4%, yielding an overall response rate of 60%. Survey data were weighted by Westat to reflect the likelihood of sampling each student and to reduce bias by compensating for differing patterns of non-response, and a post stratification adjustment factor was calculated based on grade, gender, and race/ethnicity distribution among Connecticut students. Therefore data in this report are representative of all non-institutionalized, public high schools students in Connecticut.

School health survey information and data can be found at the following website:

http://www.dph.state.ct.us/PB/HISR/CSHS.htm | Strengths:
• Population based.
• Includes questions about risk behavior that can contribute to infection with HIV.

Limitations:
• Only 60% response rate.
• Only young people in school participated. |
| National HIV Behavioral Surveillance (NHBS) | The NHBS is a multi-state, CDC-funded system for periodically assessing risk behavior in specific groups. The project is conducted anonymously. The project has three target groups: MSM, high-risk heterosexuals (HRH), and IDU. The IDU cycle was conducted in 2005 and selected data are shown in this document. Respondent Driven Sampling (RDS) was used to recruit participants. Participants are given three coupons with which to recruit additional participants who have IDU risk. The goal was to conduct 500 interviews in 2005. Participants were recruited in Waterbury and Bridgeport. Data analysis for this document is a preliminary crude analysis (not weighted). During 2007-08 CDC will provide a final data set and conduct weighted analysis, adjusting the data to population characteristics of New Haven and Fairfield County. | Strengths:
• RDS methods allow weighting to produce population estimates.
• Over time, trends in risk behavior will be discernable.

Limitations:
• Results are limited to IDU in New Haven and Fairfield Counties. |

Appendix 3.

Glossary

Term	Care or Prevention	Definition
Accountability	Prevention	A framework for how a group and its members will be responsive and responsible to itself and the community as it carries out its mission.
AIDS Drug Assistance Program (ADAP)	Care	Administered by states and authorized under Title II of the CARE Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.
AIDS Education and Training Center (AETC)	Care	Regional centers providing education and training for primary care professionals and other AIDS-related personnel. Authorized under Part F of the CARE Act.
Application	Prevention	The health department's application to CDC for funding. Contains a proposed budget to support a specific set of prevention programs and interventions.
Antiretroviral	Care	A substance that fights against a retrovirus, such as HIV.
AIDS Service Organization (ASO)	Care	An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.
Behavioral Interventions	Prevention	Programs to change individual behaviors without an explicit or direct attempt to change the norms of the community or target population.
		See also: Intervention, Community-level Interventions, DEBIs, EBIs, Group-level Interventions
Capacity/Capacity Building	Care	Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system. And reduce disparities in care among underserved PLWH/A in the EMA.
	Prevention	An activity that increases a community's ability to deliver effective HIV prevention programs.
CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)	Care	Federal legislation created to address the unmet health care and service needs of people living with HIV disease (PLWH) and their families. HRSA administers HIV/AIDS programs under for titles and Part F of the Act.
		Title I: HIV Emergency Relief Grant Program for Eligible Metropolitan Areas. Provides formula and supplementary grants to EMAs that are disproportionately affected by the HIV epidemic.
		Title II: HIV Care Grants to States. Provides formula grants to states, US territories, D.C. and Puerto Rico to provide health care and support services for PLWH/A. Grantees must also provide therapeutics to treat HIV/AIDS under ADAP.
		Title III: HIV Early Intervention Services. Supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. Designed to prevent the further spread of HIV/AIDS, delay the onset of illness, facilitate access to services, and provide psychosocial support to PLWH/A.
		Title IV: Coordinated HIV Services and Access to Research for Children, Youth, Women, and Families. A special grant program to coordinate HIV services and access to research for children, youth, women and families in a comprehensive, community-based, family-centered system of care.
		Part F: Special Projects of National Significance Program. To support the development of innovative models of HIV/AIDS care. These models are designed to address special care needs of PLWH/A in minority and hard-to-reach populations.

Term	Care or Prevention	Definition
		Part F: AIDS Education and Training Centers. A national network of centers that conduct targeted, multidisciplinary education and training programs for health care providers.
		Part F: AIDS Dental Reimbursement Program. A grant program which assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV+ patients.
		Service categories for all CARE Act Titles: Ambulatory/outpatient medical care, Drug reimbursement programs, Health insurance, Home health care, Home- and community-based care, Oral health, Hospice services, In-patient personnel costs, Mental health services, Nutritional counseling, Rehabilitation services, Substance abuse services, Treatment adherence services, Child care services, Child welfare services, Buddy/companion services, Case management, Client advocacy, Day or respite care, Early intervention services, Emergency financial assistance, Food bank/home delivered meals/nutritional supplements, Health education/risk reduction, Housing assistance, Housing-related services, Legal services, Outreach services, Permanency planning, Psychosocial support services, Referral, Transportation, Other services (translation/interpretation), Program support, Grantee administrative costs, Quality management.
CARE Act Data Report (CADR)	Care	A provider-based report generating aggregate client, provider, and service data for all CARE Act programs. Reports information on all clients who receive at least one service during the reporting period.
CD4 Cells , CD4+ Cells	Care	These cells are responsible for coordinating much of the immune response. HIV's preferred targets are CD4+ cells, which have a docking molecule on their surface. Destruction of CD4+ cells is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.
CD4 Cell Count	Care	The number of CD4 cells per one cubic millimeter of blood. As the CD4 cell count declines, the risk of developing opportunistic infections increases. Normal adult range for CD4 cell counts is 500-1500 per cubic millimeter. A CD4 count of 200 or less is an AIDS-defining condition.
Centers for Disease Control and Prevention (CDC)	Prevention	The federal agency responsible for monitoring diseases and conditions that endanger public health and for coordinating programs to prevent and control the spread of these diseases.
Centers for Medicare & Medicaid Services (CMS	Care	Federal agency within HHS that administers the Medicaid, Medicare, State Child Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPAA).
Client-Centered Counseling	Prevention	Counseling conducted in an interactive manner responsive to individual client needs. The focus is on developing prevention objectives and strategies with the client.
Community-based Organization (CBO)	Care	An organization that provides services to locally defined populations.
	Prevention	An organization offering services to a specific group of people in a defined area.
Community Forum	Care	A small group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion.
Community Health Centers	Care	Federally funded by HRSA to provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.
Community-level Interventions (CLI)	Prevention	Programs designed to reach a defined community and to increase community support of the behaviors known to reduce the risk for HIV infection and transmission. CLIs aim to reduce risky behaviors by changing attitudes, norms and practices through community mobilization and organization.
		Examples of CLIs in the DEBI Project: Community PROMISE, Mpowerment, Popular Opinion Leader
Community Mobilization	Prevention	The process by which a community's citizens are motivated to take an active role in addressing issues in their community. Focuses on developing linkages and relationships within and beyond the community to expand the current scope and effectiveness of HIV/STD prevention.
Community Planning Group (CPG)	Prevention	The official HIV prevention planning body that follows the Guidance to develop the comprehensive HIV prevention plan for the project area.

Term	Care or Prevention	Definition
Community Services Assessment (CSA)	Prevention	A description of the prevention needs of people at risk for spreading and becoming infected with HIV, the prevention interventions/activities implemented to address these needs, and service gaps. Comprised of Resource Inventory, Needs Assessment, and Gap Analysis.
Co-morbidity	Care	A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.
Comprehensive HIV Prevention Plan	Prevention	An overview of all HIV prevention programs and activities occurring in the jurisdiction.
Concurrence	Prevention	Refers to the CPG's belief that the health department's application for HIV prevention funds reflects the CPG's target population and intervention priorities.
Consensus Model	Prevention	A decision-making method in which a group holds discussions on an issue and arrives at a decision as a group. The group agrees without voting.
Consortium/HIV Care Consortium	Care	A regional or statewide planning entity established under Title II of the CARE Act to plan and sometimes administer Title II services. An association of health care and support service agencies serving PLWH/A under Title II.
Continuous Quality Improvement	Care	An ongoing process that involves organization members I monitoring and evaluating programs to continuously improve service delivery.
		See also: Quality Improvement
Continuum of Care	Care	An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH/A.
Counseling and Testing	Prevention	The voluntary proves of client-centered, interactive information sharing in which an individual learns basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection, and takes a test.
Counseling, Testing, Referral, and Partner Notification (CTRPN)	Prevention	Voluntary HIV/AIDS counseling and testing, referral to appropriate medical and social services, and anonymous or confidential notification of sex and needle-sharing partners by health department staff.
Cultural Competence	Care	The knowledge, understanding and skills to work effectively with individuals from differing cultural backgrounds.
	Prevention	The knowledge, understanding and skills to work effectively with individuals from differing cultural backgrounds.
Diffusion of Effective Behavioral Interventions (DEBI)	Prevention	A national level strategy to provide training and ongoing technical assistance on selected evidence-based HIV/STD interventions to state and community HIV/STD program staff.
DEBI Project	Prevention	A set of 12 interventions listed by their primary population or risk group, which can target multiple populations and risk groups and are packaged in user-friendly kits. The interventions are:
		Community PROMISE (Community Level Intervention)
		Healthy Relationships (HIV+)
		Holistic Health Recovery Program (HIV+ IDU)
		Many Men, Many Voices (Gay men of color)
		Mpowerment (Young MSM)
		Popular Opinion Leader (MSM)
		Real AIDS Prevention Program (Sexually active women and male partners)
		Safety Counts (IDU and non-injecting drug users)
		SISTA (sexually active women)
		StreetSmart (runaway homeless teens)
		Teens Linked to Care (HIV+ youth)
		Voices/Voces (African-American and Latino/a heterosexuals)
Demographics	Prevention	The statistical characteristics of human populations, such as age, race, ethnicity, and sex, that can provide insight into the development, culture, and sex-specific issues that the intervention will need to account for.

Term	Care or Prevention	Definition
Division of Service Systems (DSS)	Care	The division within HRSA's HIV/AIDS Bureau that administers Title I and Title II of the CARE Act.
Early Intervention Services (EIS)	Care	Activities designed to identify individuals who are HIV+ and get them into care as quickly as possible. Funded through Titles I and II, includes outreach, counseling and testing, information and referral services. Under Title III, also includes comprehensive primary medical care for PLWH/A.
Effective Behavioral Interventions (EBI)	Prevention	Evidence-based program models that were proven effective with a given population in a given venue through rigorous research studies. In order to be proven effective they had to produce positive behavior change among participants such as increased condom use, or produce positive health outcomes such as a reduction in the number of new infections.
Eligible Metropolitan Area (EMA)	Care	Geographic areas highly impacted by HIV/AIDS that are eligible to receive Title I CARE Act funds.
Epidemic	Care	A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the population. Epidemic diseased can be spread from person to person or from a contaminated source such as food or water.
	Prevention	The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.
Epidemiologic Profile (Epi Profile)	Care	A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.
	Prevention	A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.
Epidemiology	Care	The branch of medical science that studies the incidence, distribution, and control of disease in a population.
	Prevention	The study of factors associated with health and disease and their distribution in the population.
Exposure Category	Care	How an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.
		See also: Transmission Category, Risk Factor/Behavior
Family Centered Care	Care	A model in which systems of care under Title IV are designed to address the needs of PLWH/A and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.
Focus Group	Prevention	A method of information collecting involving a carefully planned discussion among a small group of individuals from the target population led by a trained moderator.
Formula Grant Application	Care	The application used by EMAs and states each year to request an amount of CARE Act funding, which is determined by a formula based on the number of reported AIDS case in their location and other factors.
Gap Analysis	Prevention	A comparison of the needs of high-risk populations, as determined by the needs assessment, to existing service as described in the resource inventory.
Grantee	Care	The recipient of CARE Act funds responsible for administering the award.
Group-level Interventions (GLI)	Prevention	Health education and risk reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. These involve a wide range of skills, information, education and support.
		Examples of GLIs in the DEBI Project: Healthy Relationships, Holistic Health Recovery Program, Many Men, Many Voices, SISTA, Teens Linked to Care, Voices/Voces
Guidance	Prevention	The CDC document that gives information and rules for receiving funds for HIV prevention programs and defines the process of HIV prevention community planning.
Health Education and Risk Reduction Interventions (HE/RR)	Prevention	Organized efforts to reach people at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. The goal is to reduce the risk of infection.

Term	Care or Prevention	Definition
Highly Active Antiretroviral Therapy (HAART)	Care	HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels.
HIV Disease	Care	Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.
HIV Prevention Community Planning	Prevention	The cyclical, evidence-based planning process in which authority for identifying proprieties for funding HIV prevention programs is vested in one or more planning groups in a state or local health department that receives HIV prevention funds from CDC.
HIV/AIDS Bureau (HAB)	Care	The bureau within HRSA of the US Department of Health and Human Service (HHS) that is responsible for administering the Ryan White CARE Act.
HIV/AIDS Dental Reimbursement Program	Care	The program within the HRSA HAB's Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to PLWH/A.
Home and Community Based Care	Care	A category of eligible services that states may fund under Title II.
Housing Opportunities for People with AIDS (HOPWA)	Care	A program administered by the US Department of Housing and Urban Development (HUD) that provides funding to support housing for PLWH/A and their families.
Health Resources and Services Administration (HRSA)	Care	The agency of the US Department of Health & Human Services that administers various primary care programs for the medically underserved, including the Ryan White CARE Act.
Housing and Urban Development (HUD)	Care	The federal agency responsible for administering community development, affordable housing, and other programs including HOPWA.
Incidence	Care	The number of new cases of a disease that occur during a specified time period.
	Prevention	The number of new cases of a disease diagnosed in a defined population in a specified period.
Incidence Rate	Care	The number of new cases of a disease that occur in a defined population during a specified time period, often expressed per 100,000 persons.
	Prevention	The number of diagnoses of new cases of a disease diagnosed in a defined population in a specified period, divided by that population. It is often expressed per 100,000 persons.
Individual-level Interventions	Prevention	Health education and risk reduction counseling provided to one person at a time. These assist clients in making plans to change individual behavior and to appraise their own behavior. These also help clients obtain services.
Injection Drug Users (IDU)	Care	Injection drug user.
	Prevention	People who are at risk for HIV infection through the shared use of equipment used to inject drugs with an HIV-infected person.
Intervention	Prevention	An activity or set of related activities intended to bring about HIV risk reduction in a particular target population using a common strategy of delivering the prevention message. Has distinct objectives and a protocol outlining the steps for implementation.
Jurisdiction	Prevention	An area or region that is the responsibility of a particular governmental agency. Usually refers to an area where a state or local health department monitors HIV prevention activities.
Key Informant Interview	Prevention	An information collection method involving in-depth interviews with a few individuals carefully selected because of their personal experiences and/or knowledge.
Lead Agency	Care	The agency within a Title II consortium that is responsible for contract administration, also called a fiscal agent.
Medicaid Spend-down	Care	A process whereby an individual who meets the Medicaid medical eligibility criteria but has income that exceeds the financial eligibility ceiling, may "spend down" to eligibility level. The individual does this by deducting accrued medically related expenses from countable income.

Term	Care or Prevention	Definition
Met Need	Prevention	A requirement for HIV prevention services within a specific target population that is currently being addressed through existing HIV prevention services. These are available to, appropriate for, and accessible to that population as determined through the resource inventory and assessment of prevention needs).
Migrant Health Centers	Care	Federally funded by HRSA's Bureau of Primary Health Care, centers provide a broad array of culturally and linguistically competent medical and support services to migrant and seasonal farm workers and their families.
Minority AIDS Initiative (MAI)	Care	A national initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. Enacted to address the disproportionate impact of the disease in such communities.
Multiply Diagnosed	Care	A person having multiple morbidities (e.g., substance abuse and HIV infection). See also: Co-morbidity
Needs Assessment	Care	A process of collecting information about the needs of PLWH/A (both those receiving care and those not in care), identifying current resources available to meet those needs, and determining what gaps in care exist.
	Prevention	The process of obtaining and analyzing findings to determine the type and extent of unmet needs in a particular population or community.
Nonconcurrence	Prevention	A CPG's disagreement with the program priorities identified in the health department's application for CDC funding. Nonconcurrence may also mean that the CPG things the health department has not fully collaborated in developing the plan.
Office of Management and Budget (OMB)	Care	The office within the executive branch of the federal government that prepares the President's annual budget, develops the federal fiscal program, oversees administration of the budget, and reviews government regulations.
Opportunistic Infection or Condition	Care	An infection or cancer that occurs in persons with weak immune systems due to HIV, cancer, or immunosuppressive drugs. Kaposi's Sarcoma, toxoplasmosis and pneumocystis pneumonia are examples.
Outcome Evaluation	Prevention	The assessment of the immediate or direct effects of a program on the program participants. Also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population.
Outreach	Care	Principal purpose is to identify people with HIV disease, particularly those who know their HIV status, so that they may become aware of and enrolled in ongoing primary care and treatment.
	Prevention	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high risk individuals in the clients' neighborhoods or other areas where clients congregate. Usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials.
Partner Counseling and Referral Services (PCRS)	Prevention	A systematic approach to notifying sex and needle-sharing partners of HIV+ people of possible exposure to HIV to partners can avoid infection, or, if already infected, can prevent transmission to others. PCRS helps partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment, and prevention services.
Patient Referral	Prevention	When the client (patient) notifies and refers his or her own partners for HIV testing.
Planning Council	Care	A planning body appointed or established by the Chief Elected Official of a TGA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish proprieties for the use of Title I CARE Act funds.
Planning Process	Care	Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.
PLWHA	Care	People living with HIV or AIDS.
	Prevention	
Prevalence	Care	The total number of persons in a defined population living with a specific disease or condition at a given time.
	Prevention	The total number of persons in a defined population living with a specific disease or condition at a given time.

Term	Care or Prevention	Definition
Prevalence Rate	Care	The proportion of a population living at a given time with a condition or disease.
	Prevention	The number of people living with a disease or condition in a defined population at a given time, divided by that population. Often expressed per 100,000 persons.
Prevention Case Management (PCM)	Prevention	Client-centered HIV prevention activity with the goal of promoting the adoption of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs. A hybrid of HIV risk reduction counseling and traditional case management.
Prevention Need	Prevention	A documented necessity for HIV prevention services within a specific target population. The documentation is based on numbers, proportions, or other estimates of the impact of HIV or AIDS among this population from the epidemiologic profile. Also based on information showing that members of this population are engaging in behaviors that place them at high risk for HIV transmission.
Prevention Program	Prevention	A group of interventions designed to reduce disease or other negative results among individuals whose behavior, environment, and/or genetic history place them at high risk.
Prevention Services	Prevention	Interventions, strategies, programs and structures designed to change behavior that may lead to HIV infection or other disease.
Primary Prevention	Prevention	To reduce the transmission and acquisition of HIV infection through a variety of strategies, activities, interventions, and services.
Priorities	Prevention	In community planning, a rank-ordered set of target populations and recommended interventions for those populations.
Priority Setting	Care	The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.
Process Evaluation	Prevention	A descriptive assessment of a program's actual operation and the level of effort taken to reach desired results; that is, what was done, to whom, and how, when, and where.
Protease Inhibitor	Care	A drug that binds to and blocks HIV protease from working, thus preventing the production of new virus.
Provider Referral	Prevention	When health professionals, usually from the health department, notify the patient's partners of their exposure.
Public Health Surveillance	Prevention	An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases in order to monitor these health problems to detect changes in trends or distribution.
Qualitative Data	Prevention	Data presented in narrative form, describing and interpreting the experience of individuals or groups.
Quality	Care	The degree to which a health or social service meets or exceeds established professional standards and user expectations.
Quality Assurance (QA)	Care	The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective.
Quality Improvement (QI)	Care	An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery.
Quantitative Data	Prevention	Data reported in numerical form.
Rank Order	Prevention	A list of priorities in order of importance.
Reflectiveness	Care	The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.
Relevance	Prevention	The extent to which an intervention plan addresses the needs of affected populations in the jurisdiction and of other community stakeholders. Also the extent to which the population targeted in the intervention plan is consistent with the target population in the comprehensive HIV prevention plan.
Representative	Care	Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Term	Care or Prevention	Definition
	Prevention	Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.
Resource Allocation	Care	The Title I planning council responsibility to assign CARE Act amounts or percentages to established priorities across specific service categories, geographic areas or populations.
Resource Inventory	Prevention	The existing community services for HIV prevention. Consists of the current HIV prevention and related resources and activities in your project area.
Risk Factor or Risk Behavior	Care	Behavior or other factor that places a person at risk for disease; for HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.
	Prevention	Whatever places a person at risk for disease; for HIV/AIDS, this includes such factors as sharing injection drug use equipment, unprotected male-to-male sexual contact, and commercial unprotected sex.
		See also: Exposure Category, Transmission Category
Secondary Prevention	Prevention	To prevent a person living with HIV from becoming ill or dying as a result of HIV, opportunistic infections, or AIDS, through a variety of strategies, activities, interventions, and services.
Seroprevalence	Care	The number of persons in a defined population who test HIV+ based on HIV testing of blood specimens. Presented as a percent of total specimens or as a rate per 100,000 persons tested.
	Prevention	The number of people in a population who test HIV+ based on serology (blood serum) specimens. Often presented as a percent of total specimens or as a rate per 1000 persons tested.
Service Gaps	Care	All the service needs of all PLWH/A except for the need for primary health care for individuals who know their status but are not in care. Include additional need for primary health care for those already receiving primary medical care.
STD	Care	Sexually transmitted disease
Statewide Coordinated Statement of Need (SCSN)	Care	A written statement of need for the entire state developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination.
Substance Abuse & Mental Health Services Administration (SAMHSA)	Care	Federal agency within HHS that administers programs in substance abuse and mental health.
Surveillance	Care	An ongoing, systematic proves of collecting, analyzing and using data on specific health conditions and diseases.
	Prevention	The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition.
Surveillance Report	Care	A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.
	Prevention	Documents on the number of reported cases of a disease, nationally and for specific locations and subpopulations.
Target Populations	Care	Populations to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.
	Prevention	Groups of people who are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior.
Technical Assistance (TA)	Care	The delivery of practical program and technical support to the CARE Act community. TA is to assist grantees, planning bodies, and affected communities in designing, implementing and evaluating CARE Act-supported planning and primary care service delivery systems.
	Prevention	The provision of direct or indirect support to build capacity of individuals or groups to carry out programmatic and management responsibilities with respect to HIV prevention.

Term	Care or Prevention	Definition
TGA	Care	Transitional grant area. A classification category specified in the Ryan White HIV Modernization Act of 2006 used to group geographic areas in calculating Ryan White funding. The minimum requirement to be classified as a TGA is a 5 year cumulative total of 2000 AIDS cases.
Transmission Category	Care	A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.
	Prevention	In describing HIV/AIDS cases, the same as exposure categories. The categories are based on how an individual may have been exposed to HIV.
		See also: Exposure Category, Risk Factor/Behavior
Unmet Need	Care	The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.
	Prevention	A requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population.
Viral Load	Care	The quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.
Weighting	Prevention	A method for determining the level of importance of two or more options relative to one another. Used to compare factors for populations and interventions.

Connecticut Department of Public Health
HIV/AIDS Surveillance Program

Epidemiologic Profile of HIV and AIDS in Connecticut
2007

FEEDBACK FORM:

1.   What is your primary involvement with HIV/AIDS?

      ☐ Community Planning Group   ☐ Ryan White

      ☐ Other, _____

2.   How would you characterize the usefulness of the Epidemiological Profile?

      ☐ Very useful   ☐ Some what useful   ☐ Not very useful

3.   What suggestions do you have for improvement of the Epidemiological Profile.

      a.   _____

             _____

      b.   _____

             _____

4.   Other comments?

      a.   _____

             _____

      b.   _____

             _____

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